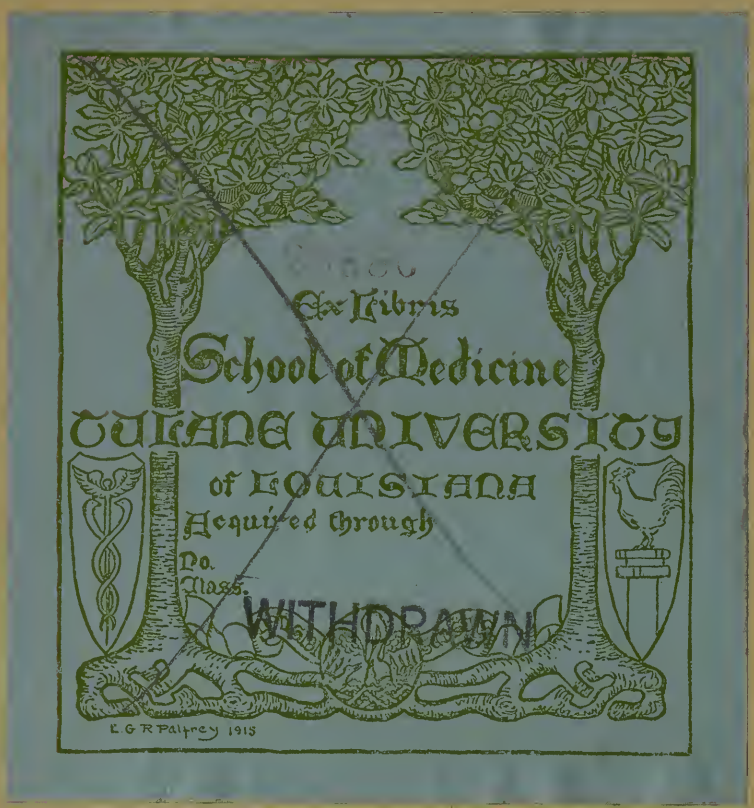
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THE JOURNAL

OF THE

Indiana State Medical Association

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

Issued Monthly
Under the Direction of the Council

ALBERT E. BULSON, B.S., M.D., F.A.C.S.
Editor and Manager

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VOLUME XXI JANUARY, 1928 NUMBER 12

ORIGINAL ARTICLES

CATHETER CYSTITIS—A MISNOMER*

HUGH CABOT, M.D.
ANN ARBOR, MICHIGAN

In the first place, may I say how glad I am to be here? Many of us look to Indiana, with its remarkable organization, for evidence of progress and evidence of good organization. There has been much which this society has done in the last year to justify the good things that have been heard of it, and particularly would I compliment you upon the way in which you have spread the gospel to the public. I think it is the feeling of everyone that our reticence of the past, on the whole, has been outgrown and that we are well advised to take the public far more into our confidence than was the habit of our eminent predecessors.

I wish to plead the cause of the defendant. Many years ago an indictment was drawn against the catheter, and it has been connected in an unsavory way with happenings to the human body which were very unprofitable to that body. I refer to the connection which, at least in the literature, has been frequently claimed between the catheter and infections of the urinary tract. The term "catheter cystitis" is one upon which we were all brought up. It was an accusation brought in good faith, I think, but I feel now that it is time this matter should be brought to trial, and I, therefore, appear as counsel for the defense.

One charge is that the catheter in some mysterious way in and of its own motion results in damage to the plaintiff; he is accused of being an objectionable person who in some way should be abated as a nuisance. Inquiring into the validity of this accusation, I think we can point out certain situations in which the case will become clear. Obviously, it is not proper to bring an indictment against the catheter in a case where there is already present outstanding infection of the urinary tract. In such a case the plea might well be made that the damage already had been done. We should, therefore, select some situation in which infection is not present and see what relation the catheter can be shown to bear to unfortunate happenings when they occur.

The most simple case, the clearest case in which the circumstances are such that the evidence can be brought out is that which occurs in cases of so-called reflex retention of urine. I mean that group which occurs after operation, which is not uncommonly seen after severe injuries, and which may occur under many conditions which put the human body out of joint. One sees it in severe illnesses having no surgical bearing. The condition appears to arise by the throwing out of joint of the reflex mechanism of the bladder. It has been suggested that pain following along the course of the efferent nerves so blocks the tract that the normal stimuli from the bladder are overwhelmed. That seems a most simple explanation and is one which I believed and taught for years. I confess that recent work tends to cast doubt upon the simplicity of the process, and I want to call to your minds that the reflex mechanism concerning itself with urination is a complicated and not a simple process. It requires the interaction of a complicated group of muscles. However, the normal mechanism is interfered with under the conditions which I have pointed out, and there results a condition in which the bladder becomes distended beyond its normal capacity, and the patient is quite unable to overcome the functional disorder. Of course, we must exclude those cases in which any suggestion of organic obstruction exists.

It has been true in the past and is still true to some extent, that under those conditions the introduction of a catheter to empty the bladder is followed by evidence of infection, hence the alleged connection of the catheter with the process. There can be no doubt that in point of time at least the catheterization of the over-distended, uninfected bladder is in from fifteen to twenty percent of cases followed by infection. It is, I think, one of the instances in which our reasoning has followed *post hoc propter hoc* methods. The bladder was known to have been uninfected; the urinary tract was normal; reflex retention occurred, over-distension occurred, the catheter was used, and infection resulted—hence, the case against the catheter. I think we have here a situation in which we can investigate, to the best advantage, the charges against the catheter.

*Presented before the Indiana State Medical Association at the Indianapolis session, September, 1927.

What are the facts in regard to the ease or the difficulty with which the urinary tract may become infected? They are, I think, not quite appreciated. I feel that a very considerable number of the medical profession are still unfamiliar with what seem to be very important facts in regard to the ability of the lower urinary tract to resist infection. For instance, it is true, although not generally appreciated, that the simple introduction of bacteria into the normal bladder never results in infection. That, I think, has been accepted the world over. As a matter of fact, it is quite within our own knowledge, because we know that no instrument can be introduced into the bladder without carrying with it, at the same time, from an always contaminated urethra, some bacteria. Some years ago we carried out some experiments in Boston with patients known to have uninfected bladders, on whom cystoscopy was necessary, and we studied the bacterial content of the urine before and after that procedure, always alleged to be harmless by the doctor, always thought to be harmful by the patient. I confess to some sympathy with the patient. We found in the group of cases studied that the urine in twenty-four to forty-eight hours after cystoscopy in almost every instance showed the presence of bacteria. In other words, bacteria had been introduced. I do not need to press the point to this group that cystoscopy, properly carried out, does not result in bladder infection. Should it do so with the regularity that might be expected, many of us who have employed that method would be lodged in jail. I should probably be out, having served my time, but my younger colleagues would still be enjoying the hospitality of the state. Experimental as well as clinical evidence is sufficient to show that the introduction of bacteria into the bladder will not, in and of itself, produce objectionable consequences.

I have thought it wise during the last five years to repeat those experiments carried out on animals for the production of artificial retention with its relief, with the introduction of bacteria and with the doing of intentional damage to the mucous membrane. We have been able to confirm the work of much abler observers to the effect that the introduction of bacteria into the normal bladder is quite harmless; that moderate degrees of trauma to that bladder, with or without the introduction of bacteria, is again quite harmless, and that none of the happenings which might be expected to result from the introduction of the catheter, even from the introduction of instruments of considerably greater traumatic possibilities, as for instance the cystoscope, is at all likely to be followed by infection. I think it is safe to say, and to confess, that the introduction of a ureteral catheter into the ureter is not a proceeding which is entirely free from trauma, though it is almost invariably possible to carry it out without discomfort to the patient, which he regards as exceptional. But if you have occasion, as we do sometimes, to examine a bladder in which the normal ureter has been catheterized within twenty-four to forty-eight hours, you will have no difficulty in deciding which ureter was catheterized, even though the best skill was used. In other words, intra-vesical examinations are not carried out without some trauma. On the other hand, that trauma is not followed by objectionable consequences.

What, then, are the conditions which may be expected to give rise to infection of the bladder, because we admit at the start that the charge against the catheter is a serious one, that the bladder having become over-distended and the catheter having been introduced, that in something like one case out of five infection does in fact occur. What is the element in that situation which is vital? It is perfectly simple. The extraordinary thing is that it has not been more generally recognized. The single necessary condition for the production of infection of the urinary bladder is over-distention and relief. It is within the knowledge of all of you that over-distention without relief will not produce infection. Most of you, perhaps for years, have seen patients whose bladders have been over-distended for periods varying from a few months to a year, and with no infection. I refer to the group of unfortunates who are engaged in a constant battle with their prostates, in whom residual urine in considerable amount constantly exists, and in whom as yet no infection has occurred. That may seem unusual, but I would point out that here the essential emptying of that bladder has not occurred. I would further point out, although it is a little off the point, that there is no group of cases in which an infection will result with more certainty following the introduction of a catheter than in this very group, provided the bladder is emptied.

If it be true, and statistics appear to bear it out, that in reflex retention where there is no obstruction infection is consequent upon emptying the over-distended bladder in something like one case in five, then a very much higher proportion of infection may be expected in those cases in which obstruction does exist. The emptying of these bladders which have been over-distended on account of obstruction is followed by infection in a high percentage of cases and in my own hands I have come to assume that infection will occur and that in this group it can rarely be avoided. That it is avoided or that it does not result in many cases in which the over-distention is not associated with obstruction must, I think, be laid at the door of the relatively short duration of the process. In this group of cases the reflex distention or over-distention may be spoken of as acute, and consequently the changes which go on in the bladder wall caused by retention are relatively short-lived, the bladder wall rapidly returns to its normal condition, and it is undoubtedly better able to resist infection.

But the first point I wish to make in defense of the catheter is that it has not as yet been shown to be an important factor in the production of infection. The catheter in its introduction of necessity carries with it bacteria, but the carrying of bacteria is not objectionable under normal conditions. The catheter in its introduction probably always commits some degree of assault upon the mucous membrane, but it has been proven that even considerable degrees of assault which we refer to as cystoscopic examinations are not followed by infection, so that the introduction of bacteria even in connection with assault upon the bladder is not sufficient to cause infection. It has been shown experimentally, and there is ample clinical evidence of the same fact, that over-distention of the bladder alone is entirely sufficient to cause infection. In animals the production of artificial retention for varying periods is followed by infection and inflammation in over eighty-five percent of our experimental cases. Our experiments and others tend to show that it is immaterial whether bacteria are introduced into the bladder which has been over-distended or not. We were unable to see in the specimens any great difference between those cases in which the bladder was allowed to become over-distended and then relieved, and those in which it was allowed to become over-distended, relieved and then infected.

Why should over-distention be objectionable? Why does it appear to be the only necessary factor in this process? I think that rests upon a very important doctrine which, to use a legal phrase, runs much more widely in the field of medicine, and which may be referred to as "the doctrine of the prepared soil." In medicine in general we are aware that infection, whether of a surgical or a medical type, occurs in one person under a certain set of circumstances, and does not occur in another person under apparently similar circumstances. What is the difference? We talk about that beautiful and vague thing, immunity. I am still vague in my mind as to what is the essential factor in immunity, particularly in what we call natural immunity. But I am perfectly clear that the condition of the soil upon which infection falls is a factor of practical importance. Of that there is no doubt. The soil is prepared for infection when its resistance is lowered. It is within the knowledge of most of us that the efforts of the skillful surgeon are generally followed by infection in but few cases, and that the efforts of the tyro are followed by infection in a larger number of cases. The skillful surgeon leaves behind him as little as may be of damaged tissues, dead spaces, and blood clots. The unskillful surgeon leaves behind him plenty of all of these factors. It is not necessary to assume in any of those cases the introduction of infectious agents in gross amounts. We know enough of the ubiquitous character of bacteria to assume that where the soil is prepared for bacterial growth there bacteria will find their way. They are constantly present on the surface of the body, they are present in enormous numbers at all points where the interior of the body communicates with the surface, so that the source of supply of bacteria will be readily found when the soil is prepared.

Now in the over-distended bladder you have apparently a majority of the necessary factors of prepared soil. The bladder, as you all know, is a hollow muscular organ, of which the muscular wall constitutes a considerable part, lined on the inner side with mucous membrane, and on the outer surface with the peritoneum. That wall is capable of a certain degree of stretching and contraction, and to that reasonable degree the blood supply has become accustomed. We know the tortuous character of the vessels of the bladder when contracted. We also know that the bladder which is asked to accommodate itself to a capacity above the normal will still be reasonably good-natured about it. If you ask what is the normal capacity of the human bladder, we are obliged to reply, "God only knows!" It undoubtedly has an enormous variation within the normal, but there is a point beyond which distention of the bladder, at least for that individual, may be regarded as entirely abnormal. At that point—when the bladder reaches the point of its normal capacity, there then begins a process of stretching of the whole bladder wall which results in compression of its blood supply. That the bladder is capable of an enormous degree of distention without rupture is common knowledge. In fact, rupture of the normal bladder by natural forces is probably unknown. Let us assume that the bladder has been distended beyond its capacity for a reasonable period. It must be assumed that it is incapable of emptying itself—it is incapable of employing the normal reflex mechanism of emptying. Let us assume that it has been emptied and contracted into the double V shape which it normally occupies. What, then, is the condition of the mucous membrane? If you look at it in microscopic section you will find it to be much thicker than normal. You will find the spaces filled with cells, that actual extravasation has taken place through the bladder wall, although not ordinarily in sufficient amount to produce gross ecchymosis. It is œdematous, its walls are swollen, and the lymph spaces as well as the vascular spaces are filled with fluid and cells. What has happened is that the circulation of the arterial side during pressure has been able to carry on. The venous side has suffered more on account of the thin wall of the veins. When collapse occurs the vein dilates tremendously, the artery dilates, and blood which is poured into the bladder wall does not leave at a normal rate, and extravasation between the cells occurs. It is within the knowledge of most of us that sudden, complete emptying of the chronically over-distended bladder sometimes results in grave bleeding, although that is much less common, I think than we might be led to believe from the literature.

This is the situation which occurs in the acute emptying with which the catheter is concerned, one in which it is the unwilling agent of bad judgment. The catheter is then made to play the goat, so to speak, in the hands of the authority which emptied this bladder at a time when it was over-distended.

I was brought up, and I think many of you were brought up, to feel that the catheter was a bad fellow, that it must be avoided. Let us take the case of a patient operated upon this morning for hernia. The house surgeon says, "What shall we do if retention occurs?" "Oh, well, see if he cannot pass his water. If he cannot, let me know." I am satisfied that there is a world-wide conspiracy between the patient and the house surgeon, because in a long and varied experience I have never found that a patient has reflex retention sufficient to require catheterization until after you have gone to bed. It makes no difference when you go to bed. I have tried it. If you go early, he will have his retention about midnight, and if you sit up until the later part of the night, he will have it about three o'clock. In a careful study I have never been able to find any case in which the surgeon had catheterized the patient in those cases in which infection has followed. There is no recorded instance. One sees here in its most perfect form the operation of the Biblical doctrine of the goat. Here is a situation which is common and under those conditions no wise man would avoid due provision, or pre-vision, for a goat. If he should catheterize the patient himself he might deprive himself of the possibility of having two goats. It is always wise to have a pinch hitter in the way of a goat. There are two kinds of goats, the house surgeon (and in that group we include his junior colleague), or the nurse. They make the finest goats in the world. This bladder having been allowed to become over-distended to a point quite beyond toleration, is emptied by the goat and the assistant goat. The goat is either the house surgeon or the nurse, and the assistant goat is the catheter. As a rule the nurse takes considerably more precautions in attempting to catheterize a patient than we would take ourselves under the same conditions. It is wise that they take it so seriously, because they will be dragged into court and accused of not being cleanly in their work, of not taking the requisite precautions. But I quite believe that it makes almost no difference whether the emptying of that bladder is surrounded by the precautions which would be employed if we were about to open the head, or whether only minor precautions are taken to avoid the introduction of bacteria into the bladder. It does not make much difference whether they are introduced that way or not, they will be introduced anyway. Many of you probably have seen cases in which a catheter was used for months or years by exceedingly uncleanly individuals, and no infection resulted. I remember the case of an old Irishman who came to my office carrying his catheter in his hat and catheterizing himself under conditions which, if I had been doing the catheterization, would have resulted in cystitis in twenty-four hours. I say that not to cast any aspersions upon the teaching in regard to the importance of asepsis in catheterization. I believe in it, but much more for the good of the soul of the catheterizer than for the good of the bladder of the catheterizee. It is very much more important to keep our souls aseptic than to keep the catheter aseptic. I know that is unsound doctrine, but I hope nobody will give me away. Therefore, I think the case against the minor goat is a weak one. I would not suggest that the case against the major goat is a weak one, because I think it is sound doctrine that all nurses and all house officers are incompetent. If it were not so we should have to answer for a multitude of our sins, but as they stand as a kind of smoke-screen between us and the patient, and as the doctrine of the goat still flourishes, we should be able to maintain the sanctity of our position for a somewhat longer period.

If it be true that it is over-distention alone that results in infection, then it must be true that it is entirely possible to avoid it—and it is. My experience—now of a good many years—with infections of the bladder in reflex retention is that the catheter is an entirely subordinate factor, and I believe that where infection follows the use of the catheter in reflex retention of urine it is invariably because bad judgment has been used in regard to the time at which catheterization has been undertaken. If that is true, what rules can one lay down to avoid infection? After all, it is a tragic group of cases. A patient having a minor operation such as for hernia, for hemorrhoids, or an operation on the female perineum, gets an infection consequent upon reflex retention which may last him or her to their death. I have known many cases where infection of that kind resulted in a long train of symptoms and finally death twenty or thirty years later. It is one of the many conditions of which cure is difficult and avoidance easy. There is one rule which may be laid down, namely, that catheterization should be instituted, not when the bladder has become incapable of emptying itself, but at a very much earlier period. This means routine emptying of the bladder before over-distention has occurred. It may occur to you that there is a tremendous human variation. What is the capacity of the human bladder? I do not know. But if you assume as a fixed amount, let us say ten ounces, as within the normal capacity of the bladder, you will be entirely on the safe side. Nearly twenty years ago I gave orders to my nursing staff and to my house staff that any patient whose bladder became distended after operation beyond ten ounces must be made the subject of report to me —and I have had few such reports. This raises the question, "How are you to tell when a bladder is distended to ten ounces?" Because after all

there is no gauge attached. You cannot tell; you have to guess at it—like much else in the practice of medicine. You know, however, that the kidney practically stops work during a surgical operation which lasts for more than fifteen minutes. Particularly is that true under anesthesia with ether or chloroform; less with "gas." The return of function is slow, and is unimportant until the patient begins to take liquids again. In the old days you could measure it by the time the patient took liquids by mouth, but today when salt solution is given under the skin the period is less easy to fix. Under the old regime when we deprived our patients of food and drink for hours beforehand, and then continued to deprive them of nourishment for hours afterwards, we were perfectly safe in assuming that the bladder would not fill up to ten ounces for at least eighteen hours. Today that is not true, but under normal conditions you are perfectly safe in assuming (of course, this is altered in the presence of nephritis) that the secretion of urine during the first six hours following operation will be less than one ounce an hour. The time of interest has dropped back from the third six hours to the second six hours. During that time the question ought to be faced squarely whether or not the bladder is reasonably distended. It has been my experience that the nursing staff and the house staff show exceedingly good judgment in this matter. They are familiar with the particular conditions surrounding the patient—the presence of fever, the amount of liquids the patient has taken, the amount of urine which the patient was secreting as normal before the operation, the character of the operation and its duration. A long operation followed by even a minor degree of shock will produce an effect upon the kidney which will reduce its secretion for a considerable period, and given such a patient there is no probability that ten ounces of urine will be secreted in the first twelve hours after operation. You at once transfer your interest to the third six hours. On the other hand, under normal atmospheric conditions, not over-hot nor very cold, in a hospital where the temperature is well maintained, a patient who has no fever, who has not been subject to a serious operation, will fall into the second six-hour zone with great certainty.

As a result of this method the catheter will be used in an enormously larger percentage of cases than has been the custom in the past. The old rule was that you should avoid catheterizing the patient just as long as possible; that was a sure route to infection. It does not result in more than one case in five, but that is not because the doctrine is sound, but because the patient is sound. The avoidance of the use of the catheter in these cases has been a cause of infection. Over-distention is the single necessary factor. I venture to assert that there are few records of infection of the bladder consequent upon reflex retention where that bladder had not become distended beyond ten ounces. Where that plan is rigidly carried out infection may be expected to disappear. Of course, there are exceptions in situations of any kind. If the nursing staff is human, error will occur. Most staffs are human, therefore errors do occur.

But by this method you can bring your associates and colleagues to the view that the burden of proof lies upon him who would avoid the catheter; that its use offers great certainty of the avoidance of infection, and that the withholding of the catheter certainly exposes to the danger of infection. The burden of proof has shifted from its position of an earlier day when the catheter was withheld to the last possible moment, when every other means was employed, generally without chance of success, until such time as the bladder had come to show the prepared soil which I believe is alone essential to infection.

So I hope as an advocate appearing for the much-abused catheter that I have made a case. I am inclined to plead to the jury that the case against my client, the catheter, is without foundation; that there is no evidence to show that the catheter ever played any considerable part in the production of infection, and that it is probably the party least properly accused of guilt in this connection.

My chief point is that the catheter as a goat has fulfilled its function, and that we shall do well to get another goat. I am inclined to take the Napoleonic view of warfare and assert that the best defense is an offense. Instead of blaming the catheter for the situation we should put the blame where it belongs, and say that in every case of infection consequent upon over-distention in reflex retention of urine, there is only one person responsible, namely, the surgeon. He cannot put an agent between him and that bladder—the catheter, the house surgeon, and the nurses are all his agents—for we may adduce against him the legal doctrine of *"Qui fecit per alienum, fecit per se."*

O-IODOXYBENZOATE ACID IN THE TREATMENT OF ARTHRITIS*

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INDIANAPOLIS

O-iodoxybenzoic acid first described by Victor Meyer in 1892 has found its way into clinical use in the treatment of arthritis through the work of Young and Youmans[1] at the University of Michigan. In the past three years they have treated a series of forty-three cases by the intravenous administration of sodium o-iodoxybenzoate, which they have recently reported.

Meyer and his co-workers[2] were first to investigate pharmacologically o-iodoxybenzoic acid and its precursors o-iodbenzoic acid and o-iodosobenzoic acid. In 1911 Lovenhart and Grove[3] undertook the investigation of the pharmacological

*Research Department, Indianapolis City Hospital.

action of certain substances which could be injected intravenously and which from their chemical nature might be supposed to increase the normal physiological action of cells. Very little light had been thrown on the increased oxidation of cells through the use of ozone and the alkalies. Pharmacological studies of the action of many of the more violent oxidizing agents had been made, but most of these could not be used intravenously. Many caused the formation of methaemoglobin, and hydrogen peroxide when injected intravenously caused the formation of gas emboli. Others such as the chlorates were not reduced in their passage through the body and it was concluded their oxygen was not available for physiological action.

Lovenhart and Grove[3] based their studies on iodbenzoic acid, iodosobenzoic acid and iodoxybenzoic acid. The latter was most effective because of its higher oxygen content. On the circulation they found iodoxybenzoic acid caused a marked and continued fall of blood pressure without any effect on amplitude and rate of the heart beat. The calibre of the blood vessels was not affected by peripheral reaction and hence it acted as a depressor of the vasomotor center. Occasionally it produced a rise in blood pressure by increasing the cardiac output.

On the respiration, iodbenzoic acid had no effect. Iodosobenzoic acid and iodoxybenzoic acid caused periods of apnoea of short duration which were due to the presence of the oxygen combined with the iodine.

O-iodoxybenzoic acid is very irritating, has a sour metallic taste and gives a peppery sensation. The sodium and ammonium salts are quite bland.

From the formula C_6H_4 (-I^0_0, -CooH(o)) Arkin[4] determined that there was 11.43 per cent available oxygen and this free oxygen should make the preparation very bactericidal.

From his studies Arkin[4] found iodosobenzoic acid and iodoxybenzoic acid had far greater bactericidal action than iodbenzoic acid. This he attributed to the oxidizing action of the former. Iodbenzoic acid can liberate no free oxygen. Iodosobenzoic acid can liberate 6.06 per cent and iodoxybenzoic acid 11.43 per cent free oxygen. Toward bacillus typhosus he found iodosobenzoic acid one hundred times, and iodoxybenzoic acid two hundred times as bactericidal as iodbenzoic acid. Iodoxybenzoic acid is twice as bactericidal as iodosobenzoic acid to bacillus coli, bacillus pyocaemus and bacillus typhosus and is 1.5 times as bactericidal as iodosobenzoic acid to the staphylococci.

PREPARATION AND ADMINISTRATION

All the patients in this series, with one exception, were hospitalized cases. Those cases which had received treatment before admission were observed for a sufficient period of time to determine the benefit of that treatment. All cases were confined to bed until after the first treatment and then their activity was governed by the joints involved, and their ability to move about. Roentgenograms were made of all the affected joints before the institution of treatment and the diagnosis was based on a careful clinical and laboratory study along with the roentgen-ray examination. In cases where a focus of infection was present an attempt was made if possible to clear it up before treatment was instituted.

No accessory treatment was employed in any of the cases treated. All patients received the regular hospital diet. Sedatives were not used with the exception of those cases in which treatment was withheld for a short time to determine the effect of previous medication.

The drug was used in the form of the ammonium salt which was prepared for intravenous use by adding sufficient sterile distilled water to the salt to produce a solution of a one per cent concentration. This solution was prepared not more than fifteen minutes prior to injection and in all cases injection was made into the cubital vein. The amount injected and the time required for injection depended largely upon the case and severity of the reaction to the drug. In the earlier cases 0.5 gram doses were used and from fifteen to thirty minutes taken for the injection while in the later cases larger doses of usually 1.0 gram were used and from five to ten minutes taken for the injection. The injections were given at intervals of three days to a week or longer apart and all cases were confined to bed for the injection and for at least six hours afterwards. Immediately following the injection a hot magnesium sulphate pack was applied at the site of injection for a period of six hours.

CLASSIFICATION AND CASE HISTORIES

The classification of cases of this series of eighteen cases is based upon clinical laboratory, and roentgen-ray examination. They have been grouped under five general heads with subdivisions under two heads. A general classification of cases is seen in Plate 1.

1. Infectious Arthritis.
 - A. Acute.
 1. One case.
 - B. Chronic.
 1. Three cases.
2. Acute Rheumatic Fever.
 1. Two cases.
3. Gonorrheal Arthritis.
 - A. Acute.
 1. Nine cases.
 - B. Chronic.
 1. One case.
4. Atrophic Arthritis.
 1. One case.
5. Hypertrophic Arthritis.
 1. One case.

Patient No.	Type of Arthritis	Sex	Age	Duration of Disease	Foci of Infection	Joint Dest.	Ankylosis	Swelling	Pain	Muscle Spasm	Temp.	Intravenous Inj.	Total Grams Acid	Duration of Treat.	Joints Involved	Relief to			Recurrence
																Pain	Swelling	Muscle Spasm	
1	Acute	M	18	1 wk.	Tonsils	None	None	Severe	Very Severe	Severe	102.°	6.	6.	6 wk.	Rt. Knee	Complete	Complete	Complete	Tonsillectomy and circumcision done. No recurrence after 8 months.
2	Chronic	F	42	4 yr.	Undetermined	Slight	Slight	Slight	Mod.	Slight	98.4°	10.	7.	10 wk.	Knee Ankle	Moderate	Complete	None	Improvement lasted as long as treatment given.
3	Chronic	M	29	4 yr.	Sinuses	Slight	None	Slight	Severe	Severe	99.°	6.	6.	3 wk.	Knees Shoulders Hips Hands	Complete	None	Complete	Improvement maintained after 1 year.
4	Chronic	F	41	8 yr.	Tonsils Teeth	None	None	Slight	Very Severe	Severe	99.2°	6.	5.5	6 wk.	Knee Elbows	Moderate	Complete	Moderate	Recurrence after treatment was discontinued.
5	Acute Rheumatic Fever	M	31	2 wk.	Tonsils	None	None	Severe	Very Severe	Severe	102.5°	4.	2.	2½ wk.	Elbows Knees Shoulders Hands Ankles	Temporary	None	Slight	No improvement, patient put on salicylates.
6	Acute Rheumatic Fever	M	16	6 wk.	Tonsils	None	None	Mod.	Mod.	Mod.	102.°	2.	1.	1 wk.	Ankles Knee	Complete	Complete	Complete	No recurrence after 8 months.
7	Gonorrheal	M	21	1 da.	G. C. Urethritis	None	None	Severe	Severe	Mod.	98.°	6.	3.5	4 wk.	Ankle Knee	Complete	Complete	Complete	No recurrence after 11 months.
8	Gonorrheal	M	19	5 da.	G. C. Urethritis	None	None	Severe	Mod.	Mod.	100.5°	3.	2.5	6 da.	Elbows	Complete	Complete	Complete	No recurrence after 9 months.
9	Gonorrheal	M	29	5 da.	G. C. Urethritis	None	None	Severe	Severe	Severe	98.5°	6.	3.6	4 wk.	Ankle	Complete	Moderate	Complete	No recurrence after 8 months.
10	Gonorrheal	F	28	1 wk.	G. C. Endocervicitis	None	None	Severe	Severe	Severe	100.5°	5.	2.5	3 wk.	Hand Wrist	Complete	Complete	Complete	No recurrence after 6 months.
11	Gonorrheal	M	32	1 wk.	G. C. Urethritis	None	None	Severe	Severe	Mod.	98.8°	4.	3.5	3 wk.	L. Knee Ankle	Complete	Complete	Complete	No recurrence after 6 months.
12	Gonorrheal	M	25	10 da.	G. C. Urethritis	None	None	Severe	Very Severe	Mod.	99.2°	2.	2.	2 wk.	Hand Wrist	Complete	Complete	Complete	No recurrence in 7 months.
13	Gonorrheal	F	21	1 wk.	G. C. Endocervicitis	None	None	Severe	Very Severe	Severe	100.4°	2.	2.	2 wk.	Wrist	Complete	Complete	Complete	No recurrence in 6 months.
14	Chronic Gonorrheal	F	3	7 mo.	G. C. Vaginitis	None	None	Mod.	Severe	Severe	98.4°	13.	5.8	4 mo.	Knee	Complete	Moderate	Complete	No recurrence, transferred to orthopedics.
15	Gonorrheal	M	34	6 da.	G. C. Epididymitis Orchitis	None	None	None	Slight	Slight	98.6°	1.	1.	1 da.	Knee Ankle	Complete	Complete	Complete	No recurrence in 6 months.
16	Gonorrheal	M	29	5 da.	G. C. Epididymitis Orchitis	None	None	Slight	Mod.	Slight	98.6°	1.	1.	1 da.	Knee Elbow	Complete	Complete	Complete	Improvement maintained after 6 months.
17	Atrophic	M	49	3 yr.	Tonsils Teeth	M'rk'd	Mod.	Slight	Severe	Mod.	99.°	8.	5.5	10 wk.	Knees Elbows Spine Shoulders Hands	Temporary	Slight	Slight	Improvement only temporary.
18	Hypertrophic	F	68	18 mo.	Teeth	M'rk'd	Mod.	Mod.	Severe	Severe	98.°	4.	2.5	4 wk.	Hips Hands	Moderate	Slight	Moderate	Maintained her improvement for 6 months.

TABLE I. CLASSIFICATION AND RESULTS OF TREATMENT.

Case 1.—O. B., school boy, age eighteen, admitted to hospital February 7, 1927, complaining of pain, swelling, tenderness, and redness of the right knee. The onset was four days previous with dull aching pain in that knee. The symptoms continued to develop and increase in intensity until his admission to the hospital. There was no history of a preceding acute infection and no history of gonorrhea.

Examination showed a well developed and nourished white male. The teeth were in good condition and there was no acute infection in the throat. The right knee was markedly swollen and tender to pressure and an area the size of the palm of the hand on the lateral aspect of the knee was very red and was the most sensitive area to pressure. There was considerable fluid within the joint capsule. The knee was flexed at an angle of about 45 degrees and could not be extended due to the muscle and tendon spasm. Roentgenograms showed no evidence of bony changes or thickening of synovial membrane.

The patient had received salicylates and local applications, before entering the hospital, without any benefit. Treatment with ammonium o-iodoxybenzoate was begun on February 9, 1927. A total of 6.0 grams was injected, the last dose being given March 22, 1927. After the first dose there was relief of pain, considerable diminution of muscle spasm and a reduction of fluid within the joint capsule. Improvement continued with each injection. The patient has had his tonsils removed and a circumcision performed since the recovery from his arthritis.

Case 2.—O. L. F., physician, aged twenty-nine, admitted to the hospital on September 1, 1926. The onset of his disease was in 1923 at which time his left knee and right ankle became swollen, red and painful. This attack lasted about three months and then cleared up. In August of 1924, he noticed soreness of the muscles for about two months but no joint involvement occurred. In February of 1926, he developed a pharyngitis with a temperature of 104 degrees which developed into a pansinusitis involving the maxillary sinuses chiefly. In March, 1926, he had a return of his arthritis involving both knees, both hips, both hands and elbows and both shoulders. These joints became very painful, swollen and tender. This condition persisted with remissions until he entered the hospital. He had taken from sixty to ninety grains of aspirin daily with only slight relief.

At the time of admission the joints were swollen and very painful and there was severe muscle spasm. The hips were involved to the greatest extent and the patient could scarcely get around. He had lost about forty pounds of weight.

The patient was given a gram of the drug intravenously every three days for three weeks. The reactions following the injections were very severe, with burning of the nose, maxillary sinus regions, pit of stomach and the involved joints. The reaction seemed to depend upon the rate of injection. After the fifth and sixth injection he began to show marked improvement in walking and there was complete relief of pain. Patient was discharged after sixth injection and a letter four months later stated that he had maintained his improvement and had gained fifteen pounds in weight.

Case 4.—J. A., white, female, age thirty-four, admitted April 9, 1927, complaining of pain, swelling and limitation of motion in knees, ankles and right elbow.

The onset was nine years ago following the birth of her first child, at which time both knees became swollen, painful and she was unable to move them. No foci of infection were determined at the time but the condition cleared up under treatment. The following summer she had another slight attack. Since that time she has had three pregnancies and about a month following each delivery she has had a recurrence of her arthritis. The onset of the last attack was in April, 1926, at which time both knees and the left shoulder became involved. They failed to respond to medication and in June she had her teeth removed with the result that there was some reduction in the joint swelling. Since then she has had almost continuous aching, pain and limitation of motion in those joints. She has been bedfast a greater part of the time.

On admission both knees and the right elbow were moderately swollen and very painful on motion. There was limitation of motion of about twenty-five or thirty degrees in the joints. The roentgenograms were negative for bony changes. The throat was not inflamed. There was a slight myocarditis. There was a stellate tear of the cervix with moderate vaginal discharge which was negative for gonococci. A diagnosis of chronic infectious arthritis was made. On April 9, 1927, she was given a one gram dose of ammonium o-iodoxybenzoate intravenously, after which she experienced a burning of the tongue, mouth, eyes, chest, and pit of stomach. The reaction lasted about fifteen minutes and the patient remarked that there was less pain in the joints five minutes after the injection began, and thirty minutes later she was able to flex and extend the involved joints completely and without pain. This result lasted two days and subsequent injections have given her permanent relief.

Case 6.—C. H., school boy, age sixteen, entered hospital January 2, 1927. He complained of pain and swelling in the right knee with numbness of the left wrist.

The onset was three weeks previously with a sore throat followed by headache and severe chill and the next morning he was unable to get up because of stiffness and soreness in the knees and

in the soles of the feet. This cleared up in about ten days under treatment. On December 28, the patient went for an auto ride, the car broke down and the patient walked home. Next day he had a severe cold, a sore throat, and the left ankle became painful, swollen and hot. The next day the right ankle became involved and the left cleared up. Within the next forty-eight hours the left knee became involved and the ankles cleared up. On the day of admission the right knee became involved and the left began to clear up. The patient entered with a temperature of 102 degrees. On physical examination, the throat was inflamed, and patient has the appearance of a washed-out, clammy individual. The right knee was swollen, very tender, hot, red and painful. There were occasional profuse sweats. The heart was not enlarged nor in an abnormal position. The sounds were clear and distinct and there was no roughening or murmurs present. The rate was slightly increased but the rhythm was normal. A diagnosis of acute rheumatic fever was made.

The patient received half a gram of ammonium o-iodoxybenzoate on January 4, 1927. He had a moderately severe reaction with burning in mouth, throat, eyes and pit of stomach. There was no chill following the injection. The temperature began to fall after the injection until it reached normal a few days later. The following day the joints were all free from pain but there was still some swelling and muscle spasm. A second injection of half a gram was given on January 10, 1927. Improvement followed rapidly and the joints were entirely clear on January 14, 1927. No heart involvement had occurred at the time he was discharged.

Case 7.—L. N., colored, male, age twenty-one. admitted on November 5, 1926. He complained of pain and swelling in the right knee and ankle.

The onset was two months ago when patient acquired an acute gonorrheal urethritis. Two weeks later the right knee and ankle became swollen and painful. This condition cleared up in about three weeks with treatment for his acute gonorrhea. He went to work and in about two weeks he had a recurrence of pain and swelling in the right knee and ankle which continued to get worse and he entered the hospital three days later.

At the time of admission the right knee was swollen, very painful and there was a limitation of motion of about twenty-five degrees. Tendon and muscle spasm was very marked. The right ankle was markedly swollen, tender and there was moderate spasm. No urethral discharge was present.

The patient was given half a gram dose of ammonium o-iodoxybenzoate on November 27, 1926. He had no reaction at all except a few darting pains in the affected joints. The following day there was marked relief from pain. The second injection of half a gram was given on November 30, 1926, after which he experienced a burning sensation in the mouth and nose which continued about three hours. A marked decrease in muscle spasm was noticed two hours after the injection. The next day the leg could be entirely extended and flexed, pain and muscle spasm were entirely gone. He developed a urethral discharge at this time and active treatment for gonorrhea was begun. There had been very little reduction in swelling up until this time. The patient received four more intravenous injections, the last one being given December 24, 1926. He was discharged on January 2, 1927, with the knee and ankle completely cleared up.

Case 15.—R. J., white, male, laborer, aged twenty-nine. Patient had acute gonorrhea seven years ago. Urethral discharge developed two weeks ago and an acute epididymitis and orchitis followed in about a week. He entered the hospital on January 23, 1927, with an acute epididymitis and orchitis and pain in both knees and elbows. Slight muscle spasm was present but no swelling. On February 13, 1927, he received one gram of ammonium o-iodoxybenzoate intravenously with a severe burning reaction and chill. The following day there was less pain in the joints and the right testicle was much less painful. The left testicle was beginning to swell and get painful at this time. Three days later the pain and muscle spasm in the joints had entirely disappeared. The right testicle had diminished in size and there was very little pain in either testicle. He received 0.8 gram on the eighteenth and twenty-seventh of the month. The pain disappeared completely and the testicles rapidly reduced in size and the patient was discharged on March 18, 1927.

Case 16.—F. Q., white, male, age thirty-six. He has had acute gonorrhea several times. His last attack was seven weeks ago and he developed an acute right epididymitis a week before admission.

He was admitted February 25, 1927, with an acute right epididymitis and orchitis, pain in both knees and ankles. No swelling was present but he was scarcely able to walk because of the pain. He received one gram of ammonium o-iodoxybenzoate intravenously on February 25, 1927, and had a moderately severe burning reaction of the mouth, nose, eyes, stomach and right testicle. The following day there was marked reduction in the pain in the joints and testicle and some reduction in the size of the testicle. The second day after the injection the pain was entirely gone from the joints and the testicle was scarcely tender to pressure. He received a second injection of one gram on March 1, 1927. The testicle continued to reduce in size and patient was discharged on March 9, 1927, with the testicle normal in size, slight induration of the epididymis and no pain or swelling of the joints.

Case 17.—F. M., white, male, laborer, age forty-nine, was admitted to the hospital January 17, 1927. He complained of pain and soreness in the knees, shoulders, hips, feet, hands, wrists, elbows and ankles. There was some swelling of the ankles and hands, loss of strength, and limitation of motion.

His first attack of arthritis occurred three years ago, at which time the knees, feet, hands and shoulders were affected. He has been more or less troubled ever since. The last acute attack occurred five months ago. The left hip became sore and painful on motion, the left knee, right knee, neck, shoulders, feet, ankles, hands, wrists, and elbows were involved, in the order named, within three weeks. All were very painful. There was swelling of the hands, wrists, elbows and ankles, and marked muscle spasm.

Physical examination showed a well developed and nourished male. Fingers were tapering and there was atrophy of the muscles of the hands. He had a chronic pharyngitis with considerable inflammation of the mucous membrane. The teeth were in very poor condition. Roentgenograms showed atrophy of the bones of the hand with roughening of the articular surfaces and definite destruction at the end of the ulna. The foot and ankle showed considerable atrophic change. The metatarso-phalyngeal joint of the little toe showed definite destruction and dislocation. The patient had syphilis fifteen years ago. He has had acute gonorrhea three times. From the findings a diagnosis of atrophic arthritis was made.

The patient was given eight intravenous injections of o-iodoxybenzoic acid, totaling 5.7 grams over a period of six weeks. He showed no improvement that was permanent. The temporary relief that he obtained lasted as a rule about twelve hours. He was discouraged with the treatment and was transferred from the service.

Case 18.—Patient was a white female, age forty-six. Onset of the arthritis was a year and a half ago. It began with stiffness in the hip and back which continued to get progressively worse and did not improve under treatment. At the time the patient was first seen she had marked rigidity of the back with severe muscle spasm. The phalyngeal joints of both hands were swollen, tender and very painful to motion. There was pain and stiffness of both hip joints and the patient was scarcely able to move about.

She received an initial dose of one gram. Following this there was less rigidity of the back muscles and she could walk better and she also had slightly better use of the hands. She received weekly doses of one-half gram for six weeks. She improved markedly for the first three doses. The pain and muscle spasm were much diminished and the swelling was somewhat reduced. When last heard from the patient had maintained her improvement.

RESULTS

A general summary of the results of the treatment is given in Table 1.

The most striking result of the treatment was the prompt relief of pain. This came on as a rule as the reaction from the drug diminished and lasted usually from twenty-four to seventy-two hours. Subsequent doses usually relieved the pain permanently. All the acute cases in this series, and those cases in which there were no bone changes showed complete relief from pain and there has been no recurrence of this in any case. In the two cases with epididymitis and orchitis the pain in the testicles was very promptly relieved. Those acute cases in which the pain was so severe as to prevent the patient from obtaining rest were usually relieved in a short time following treatment.

The next most striking result was in the relief of muscle spasm. In cases one, four, six, fifteen and sixteen this was demonstrated very clearly. Within thirty minutes after the injection the spasm of the hamstring and gastrocenemius muscles was very noticeably reduced. In case four the patient was able to extend the leg entirely for the first time in a year, and without pain. Cases fifteen and sixteen could use the knees without any impairment of motion, but this may have been due to the relief of pain rather than muscle spasm. In the other cases muscle spasm was not relieved as promptly but usually by the end of twenty-four hours there was some noticeable reduction.

Swelling was, as a rule, the most difficult symptom to relieve. In case one there was a marked effusion into the joint which was relieved after two injections of the drug. In case nine the patient had a severe swelling of the hand which would not pit on pressure, but within a few hours after injection there was less swelling and noticeable pitting on pressure. In a majority of the cases, especially those of gonorrheal origin, the swelling remained for some time after complete relief of pain and muscle spasm. Subsequent doses of the drug served to reduce the swelling.

In the two cases with severe gonorrheal epididymitis and orchitis, the drug caused a reduction of the swelling in the testicle, which became normal in size within a few days.

Smith,[5] in his paper, points out the close similarity of o-iodoxybenzoic acid to the salicylates, which increase the permeability of loops of intestines for solutes. He draws the hypothesis that o-iodoxybenzoic acid may act similarly in the reduction of edema.

Upon the white blood count it was found that the drug produced a general leukocytosis. Counts were made just before injection and twenty-four hours following injection. This leukocytosis was chiefly in the polymorphonuclear cells. The red

blood cell count as a rule was not materially affected. After several injections there was usually a slight decrease in the number of red blood cells.

Upon temperature there was usually a slight rise following the injection of the drug, but this returned to normal within a few hours. Those cases which ran a temperature usually showed a reduction if the case improved with the treatment.

The reaction resulting from the intravenous use of the drug, in this series, was very similar to the reactions described by Young and Youmans[1] and by Smith.[5] The reaction in a majority of the cases was quite severe. One patient experienced no reaction at the time of his first injection but subsequent injections produced increasingly severe reactions. The reaction in a majority of the cases began when about thirty cubic centimeters of the solution had been injected. The reactions began with a sensation of heat beneath the tongue which rapidly took on a burning sensation involving most of the mucous membrane of the mouth, and produced a sensation similar to red pepper. This burning sensation extended to the nose, frequently causing sneezing, and to the eyes which lacrimated freely. Most of the patients experienced a burning in the epigastrium after about forty cubic centimeters had been injected. In some of the cases there was nausea and even severe cramping. Several patients complained of burning in the chest, chiefly substernal, and with the sensation that the heart was being affected. Patients with coryza almost always developed a severe headache which frequently persisted after the burning reaction had ceased. The burning sensation began to subside usually after fifteen minutes, although a slight sensation persisted sometimes for several hours. The patients perspired freely during the reaction and for a short time following, and this was followed by a feeling of exhaustion. Often those cases in which the pain had been severe went to sleep. The rate of injection influences the reaction to a slight degree. The more rapid the rate of injection the more severe was the immediate reaction, while in a slow injection the reaction was more prolonged but not as severe. Most of the patients seemed better satisfied with the rapid injections which were given in seven minutes or less, by the syringe method.

Young and Youmans[1] in their cases and Smith[5] in his series obtained partial or complete thrombosis of the vein in several instances. In this series none of the cases experienced any thrombosis of the vein in over eighty intravenous administrations. This was prevented by the immediate application of a hot magnesium sulphate pack over the site of injection for three to six hours. Some of the drug was purposely injected outside the vein in a few cases to see if thrombosis would occur, but if the pack was applied no thrombosis resulted.

The majority of the cases of this series were of the acute type, and chiefly of gonorrheal origin, in which the results have been especially good. No recurrences have occurred in any of the gonorrheal cases treated. All the cases of this type showed complete relief to pain. All but one case showed complete relief to swelling, and all but one case complete relief to muscle spasm. One patient (Case 14) was pronounced by the orthopedics staff a hopeless cripple with her legs flexed at a forty degree angle. After a few weeks treatment the leg could be extended thirty degrees and the patient was able to walk about without the slightest pain. She was then transferred to the orthopedics service for correction of the remaining ankylosis.

In the case showing atrophic bony changes the results were poor. The relief to symptoms was only slight during the treatment and there has been a complete recurrence of symptoms since then. In the case of hypertrophic arthritis the results were moderate and the patient has maintained her improvement.

Two cases of acute rheumatic fever were treated, but no definite conclusions could be drawn from the results obtained. Since the disease itself runs in cycles and remissions a large series of such cases should be treated before attempting to draw conclusions. One of the cases responded very favorably and has had no recurrence since his release; whereas the other case failed to receive any benefit other than temporary relief of pain until treatment with salicylates was instituted.

Only four cases of chronic arthritis were treated and the results, while variable, were on the whole good.

SUMMARY

Ortho-iodoxybenzoic acid has been introduced by Young and Youmans[1] of the University of Michigan in the treatment of arthritis. It owes its activity to its high percentage of available free oxygen, which probably increases cell activity, and makes it a highly germicidal agent. Its action is similar to the salicylates and in many respects is just as effective.

When used intravenously it produces a severe burning reaction, chiefly of mucous membranes and inflamed areas. It is analgesic, reduces edema, and relieves muscle spasm.

Acute joint infections are most responsive to treatment but the chronicity of the infection should not be considered a contra-indication for trial of the drug.

The removal of foci of infection and general hygienic care are to be used in conjunction with the drug in the treatment.

The prevention of venous thrombosis can be attained by the application of hot magnesium sulphate packs at the site of injection, as has been demonstrated in this series of eighteen cases.

I wish to express my appreciation to Dr. L. G. Zerfas for his counsel and co-operation in this series of cases.

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RECENT CONTRIBUTIONS IN THE STUDY OF PERNICIOUS ANEMIA*

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Following the reports of Minot and Murphy[1] on the beneficial effect of a diet containing liver, there came a new hope for the prolongation of life to patients afflicted with pernicious anemia, and also a new stimulus to medical research in an effort to unravel the symptom complex and isolate the etiologic factor.

For many years the infection theory has been gaining ground with the accumulation of evidence. At first, focal infection of teeth and tonsils was accepted as a possible source of chronic intoxication based upon the fact that pernicious anemia patients had present many such foci of infection. Later the colon was incriminated because of the association of colitis and the presence of a constant bacterial flora, chiefly B. Welchii, in the feces of such patients. Accordingly, animal experiments were undertaken by Cornell[2] and it was demonstrated that toxins produced by B. Welchii could induce anemia in the experimental animal, but the complete picture as found in the human has never been reproduced. Koessler[3], about two years ago, advanced the theory that pernicious anemia is due to vitamin deficient diet particularly A. B. and C. vitamines. He has presented statistical and experimental data to substantiate his theory. He reports[4] that seventy-five to eighty per cent of all his patients suffering from the disease have lived on a regime deficient in essential food stuffs for many years. He points out that such faulty dietary habits are not limited to the financially poor but occur among the wealthy as well. "The average man prefers meat, potatoes, gravy and pie to any other foods. Such diet is very deficient in vitamines." Experimentally, Koessler has produced marked anemia in rats with vitamin deficient diets and restored rats to normal by the introduction of vitamines in their food. Recently Simmonds[5], Becker and McCallum advanced the opinion that Vitamin E is the important constituent which controls the iron assimilation metabolism, and ascribe the success of Minot's liver diet to the richness of Vitamine E in the lipoids of the liver. Contrary to the vitamin theory is the work of Cohn[6] and Minot who have shown that the exclusive feeding of a liver fraction, which is non-protein nitrogen free and contains no vitamines, is capable of inducing the same blood regeneration as the whole liver.

Another phase of investigation has been pursued by Macht[7]. It has long been suspected by clinicians that clinical picture of pernicious anemia may be the result of some toxemia. It remained for Macht to actually prove the presence of a toxic substance in the blood serum of pernicious anemia patients by a phytopharmacologic test. The test consists in measuring the degree of inhibition of growth of lupinus albus seedlings when they are soaked in Shive solution plus one per cent pernicious anemia serum, in contrast with normal serum, or sera from patients having a marked secondary anemia or sprue. He has further shown that ultra-violet rays have a detoxifying effect upon pernicious anemia sera. This detoxifying effect of ultra-violet irradiation can be intensified by the use of fluorescent dyes such as eosin. Another interesting fact is the reduction of degree of toxicity of the pernicious anemia sera following the clinical improvement after administration of the Minot-Murphy diet.

Macht suggests that the results of liver diet might even be attributed to the abundance in the liver of fluorescent salts such as hematoporphyrin acting as sensitizers.

The beneficial effect of the use of dyes, on the course of pernicious anemia, has been reported by Conner[8] who has used gentian violet, and by McLaughlin[9] who favors mercurochrome. These authors, however, base their treatment on the assumption of combating a low grade infection rather than on the theory of exposing their patients to the action of the sensitizers.

Cohnheim[10] in 1876 first described the bone marrow changes in pernicious anemia. He regarded the anemia as due to a primary disturbance of blood formation. This view is now again gaining recognition. Another conception of the disease regards the bone marrow changes as of a compensatory nature and as the result of an attempt on the part of the organism to replace the losses arising from excessive blood destruction. This theory has been the one most generally accepted even though the evidence of increased blood destruction is not convincing. Most of the studies dealing with the pathologic changes in the bone marrow of pernicious anemia have been on post mortem material. This is misleading because it deals with the end result and not with the variable deviation from normal as the disease progresses.

Perhaps the greatest advance made in understanding the exact pathology of pernicious anemia is the work of Peabody[11]. He has studied biopsy material taken at intervals, representing the various clinical phases of the disease, thus giving us a picture of progressive changes in the

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bone marrow. The essential lesion of the bone marrow, he finds, is an hyperplasia of the myeloid cells in which the megaloblasts play the chief part. During a clinical relapse the peripheral blood shows a corresponding increase of megaloblasts and this is the most convincing diagnostic sign of pernicious anemia in adults. This hyperplasia gradually replaces the fat cells of the bone marrow, and as remission takes place, the hyperplasia recedes and the fat globules reappear so that it seems that the relapse is associated with megalocytosis. What prevents these cells from becoming normal erythrocytes is unknown, but in view of the immediate salutary effect of liver diet upon blood formation, it seems that the causative agent is a deficiency supplied by liver rather than some toxic substance from bacterial origin. However, we have nothing at present to explain the cause of the achlorhydria and the spinal cord changes. Many entertain the opinion that achlorhydria is the basic cause of the disease because of the bactericidal influence of the free hydrochloric acid in the stomach contents and its effect on protein digestion.

The outstanding feature of these contributions is the specific effect of the Minot and Murphy[12] liver diet. To date there is sufficient confirmatory data published to substantiate the results obtained by Minot and Murphy even though the period of time covered is relatively too brief to warrant definite conclusions. Diet: The diet consists of daily consumption of about 200 grams of liver with generous amounts of fruits and green leaf vegetables. The carbohydrates should be reduced, particularly animal fats. The liver may be cooked in any way desired although prolonged cooking should be avoided. Mammalian kidney has the same effect as liver and may be substituted for it. Since raw liver is more effective than cooked liver, it can be taken with orange juice as follows: Reduce liver to a fine pulp and add to it an equal volume of orange juice. Stir well and place on ice and use as desired. See appended list of liver recipes.

In almost all instances the response to the diet is prompt. The first sign of blood regeneration is shown by the appearance of an increase of reticulocytes and is followed within two weeks with a gradual rise of the red blood count from the extreme levels such as in patient No. 2, from 700,000 to the normal range of four or five millions. As this takes place the color index falls below one and the characteristic megalocytes disappear to be replaced by normal-sized erythrocytes and at times by cells of even smaller diameter. The clinical improvement somewhat parallels that of the blood except for the neurologic signs. The lemon yellow color of the skin disappears and the bile-rubin content of the blood serum falls to normal. In some instances as in patient No. 1, the ruddy appearance may be so marked as to be annoying. The appetite increases and a general feeling of well being gradually appears. The numbness, tingling, and pain in some patients improves very slowly and may take months.

The following case reports serve to illustrate:

Case No. 1.—Mr. H. was seen in consultation October 5, 1925. Age forty. Chief complaint was general weakness, pallor and numbness of extremities. This condition had been noted for a period of five months. The appetite had been poor and patient noted a loss of fifteen pounds in weight. Physical examination revealed a poorly nourished man. The skin and sclerae had a lemon yellow tinge. Numbness of feet and hands, and decreased bone conduction. Gastric analysis revealed absence of free hydrochloric acid, total acidity 20°. The erythrocytes numbered 2 million, leukocytes 6,200, hemoglobin 64% (Sahli), color index 1.6. Blood smears showed marked megalocytosis and poikilocytosis. The patient was given Fowler solution and diluted hydrochloric acid. An attempt was made to discover foci of infection but none were found. The patient was again seen January 4, 1926, somewhat improved. Blood count showed erythrocytes 2.7 million, white blood count 4,200, hemoglobin 60%, color index 1.1, megalocytosis and poikilocytosis still present. March 29, 1926, patient was put to bed because of an infected arm and the blood count showed erythrocytes 1.9 million, hemoglobin 47%. April 19, 1926, erythrocytes 700,000, hemoglobin 15%. Patient extremely ill. Transfusion advised and arsenic medication discontinued. The Minot-Murphy diet was begun. Patient refused transfusion. April 10, 1926, patient began to show decided improvement. Red blood count 1.4 million, hemoglobin 35%. May 1, 1926, red blood count 3.3 million, hemoglobin 68%, color index 1.03. Patient up and about, enjoying good appetite, consuming 300 grams of liver daily. Numbness disappeared and the skin became clear. July 1, 1926, red blood count was 4.8 million, hemoglobin 98%, color index 0.9. Erythrocytes showed normal morphology. The patient returned to his former occupation on full time. October 1, 1926, red blood count was 5.2 million, hemoglobin 98%. March 1, 1927, red blood count was 5.1 million, hemoglobin 94%. May 9, 1927, red blood count was 5.3 million, hemoglobin 97%. At this time the patient was somewhat annoyed by the redness of his face and of his own accord omitted liver from diet. September 30, 1927, red blood count was 4.6 million, hemoglobin 83%. Liver was again included in the diet and October 10, 1927, red blood count again rose to 5.3 million, hemoglobin 96%.

Case No. 2.—Patient of Dr. G. B. Allen. Female, age fifty. At time of examination, March 15, 1926, patient was taken to her bed because of marked muscular weakness and shortness of breath. Physical examination revealed anaesthe-

sia, paresthesia, and typical lemon yellow color of the skin. Bone conduction was markedly impaired. Erythrocytes numbered 700,000 per cmm, leukocytes 2,100 per cmm, hemoglobin 17%. Erythrocytes showed typical megalocytosis and poikilocytosis. Transfusion was advised but because of financial conditions not carried out. Liver diet was given and the patient took it readily. December 2, 1926, red blood count 1.5 million, hemoglobin 41%, white blood count 4,000. Patient markedly improved and walked about house. January 4, 1927, red blood count 2.5 million, hemoglobin 56%, red blood cells showed slight anisocytosis. Patient returned to her former occupation. March 3, 1927, red blood count 3.8 million, hemoglobin 67%, white blood count 5,900. Red blood cells were of normal morphology. May 10, 1927, red blood count 4.2 million, hemoglobin 80%. Patient after the initial improvement admitted that liver was only partaken of once or twice a week. All symptoms disappeared after the red count reached two million and to date patient is still free from symptoms.

Case No. 3.—Patient of Dr. A.A. Kramer. Mr. S., age fifty. Druggist by occupation. At time of examination October 15, 1926, patient complained of marked paresthesia and muscular weakness. Appetite very poor. Red blood count 1.7 million, hemoglobin 45%, white blood count 4,000. Erythrocytes showed megalocytosis and poikilocytosis. Stomach contents showed total acidity 30° and no free hydrochloric acid. Patient had difficulty in eating liver but managed to take about 100 grams four or five times per week. November 15, 1926, red blood count 2.7 million, hemoglobin 60%, color index 1.1. Morphology of erythrocytes improved. Paresthesia still present. December 1, 1926, red blood count 3.5 million, hemoglobin 70%. The skin and sclerae quite clear. Muscular weakness and paresthesia slightly improved. January 1, 1927, red blood count 4.1 million, hemoglobin 83%, red blood cells showed slight anisocytosis. Paresthesia as before. Appetite was good and muscular power improved. January 29, 1927, red blood count 4.5 million, hemoglobin 85%, white blood count 5,000. Red blood cells showed slight anisocytosis. April 5, 1927, red blood count 5.1 million, hemoglobin 88%, white blood count 7,200. Red blood cells were of normal morphology. Numbness somewhat better but patient still complained of pain in hands and feet. June 23, 1927, red blood count 4.8 million, hemoglobin 86%, white blood count 7,500. Two infected teeth were removed. August 10, 1927, red blood count 5.2 million, hemoglobin 90%, and red blood cells were normal. Paresthesia markedly improved.

Case No. 4.—Patient of Dr. A. Knapp. Was referred to confirm the diagnosis of tabes dorsalis. Physical examination revealed lemon yellow pallor. No Argyll Robertson pupil. Rhomberg positive, knee reflex exaggerated. Lumbar puncture yielded clear fluid under normal pressure. Cell count 5 per cmm, globulin negative, Wassermann negative, colloidal gold negative. August 2, 1926, red blood count 212 million, hemoglobin 63%, color index 1.4. White blood count 3,000, red blood cells showed marked megalocytosis and poikilocytosis. Liver diet was instituted. September 15, 1926, red blood count 3.1 million, hemoglobin 68%, white blood count 5,000. Red blood cells showed moderate improvement in morphology. No changes in physical findings. November 17, 1926, red blood count 4.3 million, hemoglobin 80%, red blood cells normal. Paresthesia improved but tabetic signs still present. Patient could not walk unassisted. June 10, 1927, red blood count 4.8 million, hemoglobin 85%, white blood count 7,000. Red blood cells normal. Improvement in sensation of hands and feet. Muscular weakness and tabetic gait still present. October 8, 1927, red blood count 5.5 million, hemoglobin 80%, red blood cells normal. No further improvement.

COMMENT

The above case reports substantiate results of Minot and Murphy. The inclusion of liver in the diet stimulates immediate blood regeneration within two weeks or later while the red blood cells rapidly acquire the normal morphology. The general clinical symptoms improve with the exception of the neurologic symptoms. These in some patients improve very slowly and it remains to be seen if with longer period of time any other changes take place.

GENERAL DIETARY INSTRUCTIONS FOR PERNICIOUS ANEMIA

USE	AVOID	SAMPLE MENU
Meats and Fish Liver—a large serving at least once a day in some form. Red meats—once a day such as rare steak or rare roast beef. Sweetbreads — kidneys, sardines.	Fried liver. Fatty meats such as pork or bacon.	**Breakfast** Oatmeal with cream, Poached egg, 2 slices graham toast, 2 squares butter, Coffee.
Fruits All kinds liberally, especially berries, orange, grapefruit, apricots, fresh pineapple and peaches.		**Dinner** Steak—rare, Potato, Spinach, Carrots, Celery, 1 slice whole wheat bread, 1 square butter, Apricots, Tea with milk.
Vegetables All kinds liberally, especially green vegetables.	Potato in excess.	
Cereals and Starchy Foods Oatmeal, bran, shredded wheat. Use rice and macaroni in moderation.		
Bread Whole wheat and graham bread, dry bread, toast, rusks or swiebach.	Hot breads, biscuits, muffins.	**Supper** Broiled liver, Escalloped tomatoes, 2 slices graham bread, 2 squares butter, Grapefruit salad with boiled dressing, Tea with milk.
Desserts Only the simplest.	Rice pudding, pastries, candy.	
Fats Not more than three tablespoons of butter or two tablespoons of cream.	In excess— Mayonnaise Fried foods.	
Milk Not over one cup per day.	Salty foods. Do not add salt to cooked foods.	
Egg Not over one per day.		

CREAMED LIVER

Parboil sliced liver, then cut in cubes and brown slightly with butter in a skillet, stirring frequently. Sprinkle with flour and brown, stirring constantly. Add enough rich milk to make a thick gravy.

LIVER LOAF WITH TOMATO SAUCE

3 w. liver—parboiled
3 strips of bacon—ground
1 tb. cream
1 small onion—grated
2 eggs
1 scant cup cracker crumbs

Mix ingredients and bake in a loaf, using most of the cracker crumbs to cover the outside.

LIVER DUMPLINGS

1 pound calf's liver—chopped very fine.
Equal amounts of bread soaked in water.

Squeeze bread as dry as possible. Mix with liver and one egg. Season with salt, pepper and nutmeg. Parsley may be added, if desired, or finely chopped onion. Add just enough flour to make the mixture stick together. Make into a small dumpling and drop into boiling salt water. Boil until dumpling comes to surface. Serve with browned sugar.

LIVER WITH VEGETABLES

Beef liver—sliced, 2 pounds
Fat, 2 tablespoons
Onions (small), 1 cup
Carrot or turnip (cut), 2 cups
Small potato (cut), 4 cups
Celery top or parsley, 1 tablespoon
Flour, 2 tablespoons
Salt, 2 tablespoons
Pepper, 1/8 tablespoon.

Wash and pare vegetables, put on in boiling water to cover and boil 20 minutes. Put into baking dish or casserole with stock in which they were boiled; add 1 tablespoon of flour mixed with cold water. Cover with the liver, prepared as follows: Remove skin and veins, cut into convenient pieces; sprinkle with salt, pepper and flour; put into hot pan with fat and sear quickly over hot fire. Cover dish and bake in slow oven one hour. Serve in casserole.

BOILED LIVER SPECIAL

Put a whole liver in cold water, one teaspoon to one quart water with one tablespoon peppercorns, one tablespoon allspice berries and one dozen whole cloves. Bring to boiling point, cook gently until tender (about ten minutes for calf's liver). Let cool in water, drain, slice and serve as cold meat.

MOCK TERRAPIN

Add one-half cup of chopped mushrooms to one cup of brown sauce and one and one-half cups of liver cubes. Add a dash of mustard, dash of paprika and one tablespoon lemon juice.

LIVER JUICE COCKTAIL

½ glass of juice of liver—parboiled 7 or 8 minutes
½ glass of orange juice
Pinch of salt.
Take ice cold two or three times daily

LIVER COCKTAIL

One-half pound of liver makes four tablespoonfuls of crushed product:

Sauce: Prepare a sauce as follows:
Tomato catsup (Heinz), ½ cup
Lemon juice, ¼ cup
Worcestershire sauce, 2 teaspoonfuls
Chives (finely chopped), ½ teaspoonful
Salt and pepper, to taste.

Cocktail: Mix the liver and sauce in the proportion of one part crushed liver to two and a half parts of sauce. Chill thoroughly and serve in a cocktail glass with salt crackers or wafers.

LIVER AND CORN CREOLE

Put 1 can corn and 2 cups parboiled and ground liver into a saucepan with 2 tablespoons of chopped red pepper and 1 cup milk. Cook slowly 10 minutes, season with salt and pepper and add 2 tablespoons butter. Put into a greased baking dish. Cover with bread crumbs. Dot with butter and bake 10 minutes.

LIVER CRUSHED

¼ cup liver
1 egg
½ cup milk
¼ tablespoon buttter
1 teaspoon salt

Beat egg slightly—add liver, milk and salt. Put in buttered mold and set in pan of hot water to bake in a moderate oven until firm.

HOT LIVER AND TOMATO SALAD

½ cup of ground liver seasoned with salt and pepper.

Place liver on lettuce leaf and put two slices of raw tomato over liver. Top with a sprig of parsley.

Variation—Serve horseradish or mustard sauce at one side.

BAKED CORN AND MINCED LIVER

I can corn (juice drained off)
I egg (well beaten)
1 cup ground liver (parboiled before grinding)
½ cup milk
Salt and pepper
Cover with a layer of bread crumbs
Bake until custard is done.

SCALLOPED LIVER

1 pound liver
½ cup crumbs
2 cups white sauce
1 cup tomato
1 square butter.

Parboil liver and cut in cubes. Line a buttered baking dish with cracker crumbs. Place alternated layers of liver, white sauce, cracker crumbs and tomatoes, etc. Dot layers with butter and over the top.

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GALL BLADDER CASES, (SURGICAL CLINIC*)

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Case 1.—I will take this case as the basis, to bring out some points in which I think the profession is weak in the diagnosis and study and

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treatment of gall bladder disease.

Patient was admitted August 24, complaining of pain in the epigastrium and right hypochondrium, headache, and nausea and vomiting after eating. Temperature 102, pulse 130. This woman is 55 years of age, and a housewife. The onset was three days before admission. Following the usual routine of her life, in the middle of the afternoon she began to have a heavy, uncomfortable feeling in the stomach; some indefinite pain, but in an hour the pain became more severe, beginning with the epigastrium and reaching to the right to the region of the anterior superior spine, and occasionally behind the left shoulder. This pain was of the severe, lancinating type, and the area involved was very sore. She was given "dope," which gave her only temporary relief, and she came to the hospital three days after onset.

The gastrointestinal history was that she had been constipated for years. Good appetite, no idiosyncrasies for food; very poor teeth; very little throat trouble; no gastric distress; no epigastric pain. Never had clay-colored stools or bloody stools until onset of present illness.

The x-ray findings—the picture of the gall bladder region following dye shows a large shadow opposite the transverse portion of the third lumbar vertebra; there is slight evidence of dye above the shadow. The day following admission her temperature, with all alarming symptoms, abated. She was operated on the ninth day. At operation they found a ruptured gall bladder and a stone about the size of a walnut outside the gall bladder. They drained the gall bladder and she had an uneventful recovery.

Case 2.—We see in this case a rather typical one in which there is no previous history. This woman tells me that she was always perfectly well until the time of this attack. The doctor saw her on the 24th, with a history that she had had pain enough to require "dope." I think we ought always to start with that—that if pain in the epigastrium is severe enough to require a hypodermic, it must always be attributed to some acute condition, either gall bladder, appendix, or some lesion of the stomach itself. In other words, I do not think we often see a case of indigestion requiring a hypodermic.

We noticed that on the 24th she had a temperature of 103, pulse 130, indicating a local infection about gall bladder, not a diffuse one, because of the receding of the temperature within the next few days. We notice that shortly after that the red cell count was 3,500,000; white cell count, 9,500, which would be considered normal, and which is the same after the temperature had gotten to normal. I would like to suggest that in acute cases I do not think the white cell count gives us a great deal of advantage in gall bladder cases. It might perhaps if it is taken every six hours, with a constant increase enough to cause us to think there was a rapidly forming empyema of the gall bladder. Otherwise, I consider that that portion of the examination could be left out without any consequence.

The x-ray picture here I think is interesting. As we have been told, there was a calculus outside of what might be a rounded form of gall bladder. It is possible that more of them leaked out through perforations of the gall bladder. However, I am inclined to think that after the inflammation had receded and the temperature had gone to normal there was a direct sealing off of that inflammatory mass. The operation, done through one rectus incision with ample drainage, has resulted in perfect success and the woman has had no inflammation around the scar.

This represents a rather typical case of its kind. I think we can detect from this some variation in these symptoms that other cases may have. You might say that any case that is typical ought to be easily diagnosed and studied. It is the case that we see mostly undiagnosed that shows the various phases that I would like to mention. It is the chronic case that never has an acute attack as severe as this woman had. It is the case very frequently that gives a set of symptoms that reminds you very much of hyperacidity, and yet the patient may have hypoacidity. Such a patient has a set of symptoms—some distress in the epigastrium, some slight indigestion, some gas symptoms, either belching or gas in the stomach or abdomen, all of which make a picture of what we call the gall bladder stomach. That only means that it is the stomach that accompanies a chronic gall bladder condition.

The diagnosis in such a case I think should be routine. In all of those cases a thorough previous history as well as the present clinical history should be obtained. A test meal given will in nearly all instances show a hypoacidity or sixty or seventy-five per cent of normal. There may be some of you who feel that the test meal is not very valuable. There are defects in it, but I am inclined to think that in a general way we can depend on these tests. A barium meal can be given to eliminate the stomach and intestines. It is always necessary to give a test meal first, because the barium meal will disturb the amount of hydrochloric acid in the stomach and make it subnormal. Then the picture of the gall bladder made following the dye may show a distorted gall bladder, either enlarged or contracted, and it might show the effects of adhesions to the duodenum. That has guided me in some stomach cases. I think it would be unwise to make a diagnosis depending altogether on the x-ray picture. It should be an adjunct to the clinical history, which makes it of great value.

We must consider in the diagnosis of these cases the chronic cholecystitis that has never had

an acute attack of hepatic colic, one that is the result of previous infection. We do know that infections of the gall bladder, liver and gall ducts are common, because it has been quoted in our State Journal, and from the Mayo Clinic, that they found in 600 autopsies that sixty per cent of the gall bladders were chronically infected, that is, that the patients had been operated for various other things. That will be shown also in appendix cases. I have always said that eighty per cent of appendices show some former lesion that has left adhesions. You might have a slightly different percentage in your practice, but it all indicates that both the appendix and gall bladder in a majority of cases show previous infection. If we have a gall bladder infected, then we know that in all probability we have the ducts infected, and the same is more or less true of the liver itself. So I take it from my own work that the most deficient part of our diagnosis of trouble in the upper abdomen is lack of early diagnosis of these chronic gall bladders. I think a case of this kind illustrates the case where we are not helped by our medical treatment.

My subject was to be general, and I want to say a word or two as to my opinion of such a case as we have described. We all have more or less different views about the effects of medicine, and I want you all to know that I still have plenty of confidence in medicine, although I am doing surgery. I feel inclined always to give these patients some such treatment as this—a glycotauroate compound before meals, also a good alkaline once a day, and at intervals of three or four weeks give citrate of soda, which thins the bile. Whether I am right or wrong, I have given these patients a chance before operation is suggested.

I would like to mention one case of this type that I have found. You all heard the excellent talk made by Dr. Underwood. Last month he was treating a case of acne rosacea, and while the patient was in the city she thought she had a little stomach trouble and came to us. Her history for years back was a typical history of what I have been describing as the gall bladder stomach. At no time was it sufficient to put her to bed, but she had some symptoms almost every week. This case was studied as I have told you. There was nothing much in the x-ray picture to show that the gall bladder was diseased, but the clinical stomach picture was present. An operation was done, and the pathology there was of course that which we expect to see in that kind of case. There was a gall bladder, practically normal in size. The walls seemed thick and pliable and it emptied easily but there were streaks along the peritoneum that did not look normal. We know from experience, as well as from reading the men who have larger experience, that all chronic gall bladders present this picture. That justifies removal. This gall bladder on its inner surface did not look very good—it looked just as though there had been some slight scarring at some points, just enough to know it was not normal.

What are the effects following operation? We have patients who can eat heartily every meal without distress. In the particular case of which I speak there was immediate eradication of the acne rosacea, which Dr. Underwood felt sure was the result of the absence of irritation.

Case 3.—The history of the next case is as follows: This patient entered the hospital August 24. She is a housewife, aged thirty-eight, weighing 198 pounds, five feet five inches tall. She came complaining of pain in the epigastrium and right hypochondrium region, headache, nausea and vomiting, and constipation. The onset was the day before admission—nausea following the evening meal; pain began in a few minutes—acute type in the right midline of the epigastrium and rotating to the right and toward the pelvic brim. Pain was intermittent but continual aching was present going toward the back. Flatulence was marked and regurgitation frequent, somewhat relieved by soda water. Patient walked to relieve herself, but that morning the relief was temporary. She entered the hospital the following morning, and after that had no chilly sensation.

Patient always had a good appetite; no food idiosyncrasies; nothing seemed to bring on attacks. Teeth were poor and several had been extracted. She had tonsillitis during the winter season. Two years ago she had a stiff back and pain during the night; similar subsequent attacks very severe; this was accompanied by nausea and vomiting, nose bleed, jaundice, clay-colored stools, marked flatulence and constipation. Has headache lasting two weeks. Several mild attacks first year; last year attacks more frequent—almost monthly.

Examinations showed urine negative; blood count, red cells, 4,200,000; whites, 8,000; blood chemistry, negative. x-ray findings followed sodium dye, no evidence of gall bladder filling at twelve and eighteen hours. Colonic gas confused the picture a great deal.

In this case, as in the last, the patient had a good deal of infection about the teeth. Each had defects and focal infection in other parts of the body. This infection I think predisposes to the intestinal infection through which the gall bladder becomes infected. We have here two cases which are different. The other had no previous history; this one has a very distinct history of many attacks.

In the last five minutes I would like to say this about these cases. I think the surgery done in these cases representing two incisions, one a rectus incision and the other a subcostal incision. Someone asks which is better. I think they are

both good—the results are good in both. The appendix in some cases is much easier gotten at when the incision is made through the rectus; in other cases it is done more readily by the subcostal incision. I cannot explain the difference. I believe that doctors making the subcostal incision should remember that it is more necessary to do very thorough sewing of the posterior sheath of the muscle than with the other incision, because there is more apt to be hernia. I think perhaps that is due to fibres being cut crosswise.

Drainage is much discussed now. Richter of Chicago was the first man I knew of to close without drainage. He has done that for several years, but I cannot feel secure in doing it. Occasionally, no matter how thoroughly the cystic duct is ligated, we will have bile drainage, and strange to say every surgeon I talk to has the same feeling about the matter. For a long time I tied the cystic duct off somewhat from the other tissues. I tried to get all the connective tissue away. I believe now that I hold most of them more securely by tying considerable of the fascia in the direction of the cystic artery, and sometimes I include it in the same ligature, always with chromic gut.

The question of drainage is important. I think if I had only one case in a thousand that did badly because there was no drainage, that would be too many; therefore I advocate putting in a wick for a few days at least. The drainage cases are closed within eight or nine days by granulations, and it does not prolong the convalescence of the patient.

SPECIAL ARTICLES

MEDICAL ECONOMICS

Medical economics is a subject that receives scant consideration by medical societies or even the average individual physician. This is due to the fact, rather well established, that physicians are poor business men and are unacquainted with the laws of economics. Therefore, they are the most gullible of all men when it comes to money matters and questions of pure business. In discussing this subject in the *Journal of the A. M. A.* of November 26th, M. L. Harris, of Chicago, from whose article we shall quote extensively, says that whatever may have been the causes contributing to the fact that the average physician is a poor business man, there is no reason why the physician should remain one. He points out that the sociological relations of the physician today are different than what they were fifty, twenty-five, fifteen or even ten years ago. Consequently, unless the physician gives a little more thought and study to the economic problems of today he is going to be the loser. He says that there are four parties deeply concerned: the physician, the patient, the profession, and the public. When one enters on the practice of medicine one assumes certain duties and obligations to the public, to the profession, to the patient and to himself. The obligations to the public and to the profession are in a sense moral obligations. Those to the patient are of a contractural or legal nature as well as a moral one, while those to the physician himself, except under certain considerations, are subordinate to the other two.

The average physician gives little thought to the question of economics and to the psychologic effect upon the people of the things which he does. As a concrete example, Dr. Harris mentions the so-called diagnostic laboratories, that are springing up all over the country, many of which are owned and conducted by laymen. These laboratories exist only by reason of the support given them by the physician, but the physician seldom realizes what he is doing when he refers his patients to them. He doesn't seem to appreciate the fact that he is not only curtailing his own business but also that of the profession at large. Some of these laboratories, owned and conducted by laymen, encourage patients to come direct to the laboratory instead of being referred by a physician. In fact, some of the laboratories organize clubs agreeing to examine the urine of the members at regular intervals, at so much per year, and to advise what to do in case any abnormality is found. They also perform other work, such as the examination of the blood, sputum, feces, etc. It is not that so many of these patients are lost to the profession, but much bad advice is received from such institutions and it is largely due to the fault of the medical profession. Some of these institutions advertise that they are equipped to give hypodermic medication, intravenous injections, arsphenamine treatment, mercury rubs, colonic flushings, etc., and have the audacity to ask physicians to send their patients to them for such treatment, offering *sub rosa*, of course, to divide the fee with the physician referring the case. Every physician ought to be able to make simple clinical tests, but if he is not competent to do this, or for any reason does not want to do it, he ought, in all fairness and justice to himself as well as to the patient, refer the work to a confrere who is able to do the work and is recognized as being competent. If he is a very busy physician it would be possible for him to employ a medical assistant who is trained to do laboratory work, and give such treatment as he himself does not care to give. The loss of a patient or a fee is not the only evil connected with this bad method of practice which encourages or even permits patients to go to health institutes or laboratories conducted by laymen. The psychological effect on the patient is bad. If he gets a feeling of distrust of the physician's ability it creates a tendency to seek unqualified advice.

Dr. Harris says that another great source of

loss to the profession is the failure of most physicians to give proper attention and care to those suffering from so-called minor ailments and, in consequence, patients flock to the cults and quacks. Such patients make up the bulk of the practice of the irregulars who, convincing the patient that he has some serious and remarkable condition which the physician had given up, performs a marvelous cure (?) and thereby receives undeserved credit. The medical profession should waken from its lethargy and see that these patients receive proper care and attention. When this is done there will not be so many chiropractors, osteopaths, and others of their kind who seek to practice medicine. The medical profession should see that these patients receive proper care and treatment and are not manhandled under the mistaken idea that some portion of their anatomy needs adjusting.

Another matter of importance referred to by Dr. Harris is the management of hospitals, and here he states a truism when he says that the chance of having a good hospital, where you are at liberty to take your patients and treat them according to your own ideas, is constantly growing less. The reason for this is that hospital management is being dominated more and more by laymen who fail to understand and appreciate the professional side of the situation. Lay boards and trustees of hospitals are beginning to think that every patient who enters the hospital belongs to the hospital and it is the duty of the board to determine who shall take care of him. As an example of the attitude that is assumed by some hospitals, Dr. Harris quotes the statement of a lay superintendent of a hospital who, in an article in the lay press, said, "Physicians are necessary adjuncts to a hospital but they should have nothing to say in regard to whom their confrerers should be." Is it not interesting to know that physicians are not an essential part of a hospital and that they haven't sense enough to determine with whom they shall work or have anything to say about the hospital management? The hospital is the physicians' workshop, and when a workman ceases to have anything to say about the management of his shop, he has lost his independence and soon finds himself working under someone else in the physician's place and under the dictation of laymen. The primary purpose of a hospital is for the care of the sick, and this purpose should not be diverted nor minized by the prevailing practice of so-called standardization which seems to be running some hospitals into the ground. As Dr. Harris says, "hospitals are being flooded with elaborate questionnaires, some of them asking questions which no self-respecting institution would answer, such as the names and salaries paid superintendents and other employees, and the names of the particular religion of the members of the staff, and are being over-run by young inspectors who have no knowledge of nor experience in the management of hospitals—each with an arbitrary yardstick with which to measure and weigh the hospital according to the dominant idea of the institution doing the rating. One will rate the hospital on the basis of its physical equipment; another upon its scientific paraphernalia; a third on the percentage of autopsies held; a fourth on the number of facilities for training internes; a fifth on the willingness of the members of the staff and all others practicing in the hospital to sign an iron-clad, stultifying oath concerning fees which it is acknowledged cannot be enforced and which, it is well known, is constantly being violated by a large percentage of its own members, and so on down the list, for no one seems to have grasped the idea of rating hospitals according to the amount of good they are doing for the relief of human suffering, having in mind the economic condition of the community to serve. Physicians must have strength of character enough to assert themselves in the management of hospitals. They must be imbued with the high ethical principles of the profession and see that all those who work with them are likewise ethical. This is a duty they owe to themselves, their patients and the public."

Dr. Harris very justly takes a whack at the physicians who sell their services to lay organizations organized for profit, who in turn resell the knowledge thus gained back to the patient at a much higher price. This is not only a direct financial loss to those engaged in the work but a breach of the obligation which every physician owes to the profession as a whole, as it lessens the confidence which the people have in its ability, lowers its dignity, and detracts from its independence.

Concerning the question of contract practice which, *per se*, is considered unethical, Dr. Harris says a contract is unfair and therefore unethical when the compensation received is inadequate based on the usual fees paid for the same kind of service in the class of people in the same community, or when the compensation is so low as to make it impossible for competent services to be rendered. In the first instance, price cutting under contract makes it unfair competition and leads to economic loss to the individual physician as well as to the entire profession, and in the second instance, in addition thereto, the patient suffers from inadequate service. Underbidding by the physician in order to secure a contract is not only derogatory to the dignity of the profession, and therefore demoralizing, but must lead to incompetent and inadequate care of the sick. Furthermore, a contract that denies a reasonable fee charge to physicians in a community where other competent physicians are readily available is unfair in that it annuls the patient's right to have the physician in whom he has confidence, and

the confidence of the patient is one of the greatest assets of the physician. Again, the solicitation of patients, directly or indirectly, as is done by some physicians and a number of so-called hospitals or health associations, is so unethical in every feature that it seems almost unnecessary even to mention it. In fact, every form of unethical contract practice is a distinct violation of the obligation which every physician has to uphold the honesty and dignity of the profession.

Concerning fees, Dr. Harris says that the division of fees against which the conscience of every one revolts may be passed as unethical, but there can be some discussion of the subject of the size of the fee. Honesty and fair dealing require that the fee shall be governed by the status of the patient and his ability to pay, of course, due consideration being given to the character of the services rendered. To charge a fee, regardless of what the services may have been, which the economic status of the patient makes it next to impossible for him to pay, is little short of a crime. Dr. Harris believes that those who are abundantly able to pay, should pay well for good service, but he does not feel that any physician, no matter what his eminence, whether self-assumed or not, has any legal or moral right to deliberately hold up patients *unable* to pay. As an example of highway robbery, Dr. Harris quotes an instance where a young working girl, earning about thirty dollars a week, on which she was obliged to maintain herself and her mother, was operated for appendicitis by a surgeon, and even though the surgeon knew her circumstances he presented her a bill for $1500 for the operation. She explained how impossible it was for her to pay any such amount, but the surgeon told her that she would not be permitted to leave the hospital until she produced the money. Fortunately, an attorney friend succeeded in getting her out of the hospital. In another instance, the chief surgeon of a hospital did an exploratory laparatomy on a man with an inoperable carcinoma of the stomach. At the conclusion of the operation the surgeon immediately went to the wife of the patient who was waiting in his room and asked for his fee, which he said was $5000. She said she was unable to pay such a fee, and beside that she had no money with her and her husband always paid the bills. The surgeon said that it was customary for him to have his fee when the operation was finished and she would have to make some arrangements to pay it at once. All of this was done before he informed the wife that her husband was already dead, having died on the operating table as the result of simply opening and closing the abdomen. When the real facts were known, the widow turned the bill over to her attorney. The attorney wrote to the surgeon asking if there was not some mistake in the bill, saying that the entire estate of the deceased, including life insurance, and everything, amounted to less than twenty thousand dollars. The surgeon had the audacity to reply that he was sorry that there had been a mistake, but he had forgotten to add sixty-two dollars for dressings, and sent an amended bill for $5,062. The attorney, who was a high-class professional man himself, consulted Dr. Harris as to what should be done, and it is needless to say that what Dr. Harris said was plenty! A third incident is reported in which a fake and fraudulent so-called serum was injected into the wife of a poor man, a charge of $300 being made with the promise that the injection would cure the wife of cancer of the stomach. In commenting upon this extortion Dr. Harris says that these may be exceptions, for the majority of physicians are fair and reasonable in their charges, but it does point out that the economic status of the patient should be considered in making the fee. One extortionate fee is remembered long after a hundred charities are forgotten, and the entire profession suffers for the wrongful act of one of its members. The humanitarian aspect of the practice of medicine never should be forgotten, and it imposes upon the physician certain moral obligations which cannot be repudiated.

The profession has a definite and distinct duty which cannot be delegated, and this duty is the care of the sick and suffering. It doesn't mean the care of some of the sick or even all of the sick some of the time, but it means *the care of all of the sick all of the time.* If the medical profession as a body fails to grasp and fulfill its entire duty in this respect, then will private and public institutions and legislatures step in and take the matter out of the hands of the profession. It is because the medical profession has failed to make proper provision for the care of all of the sick all of the time that we hear so much agitation about federal and state measures that inevitably tend to state medicine and the loss of the independence of the physician. Dr. Harris says that this is no idle dream, as is well shown by a recent editorial in the *Chicago Tribune,* in which is advocated corporation practice of medicine as offering the best way in which the public can be served. It is also because of the recognition of this failure that a group of public-spirited men in Chicago a short time ago organized the public health institute which today is treating on an average of eighteen hundred patients daily at a cost which they are able to pay and with great profit to the institution.

A very pointed recommendation is made by Dr. Harris when he says that the old free dispensaries, connected with medical colleges and fostered entirely for teaching purposes, met a real need, and similar institutions conducted in a strictly ethical manner at the present time would be one of the greatest assets that a patient could have. He

believes that every community should have one or more similar institutions as its need may require, enlarged to include all departments of medicine, *and conducted entirely by the profession,* where every patient unable to pay the usual fee of the physician can receive the best of medical services at a cost within his means. When this is brought about Dr. Harris says that the medical profession will then be fulfilling its entire duty to the public and itself, and on a sound business and economic basis.

NEWS NOTES FROM INDIANA UNIVERSITY

Within less than five weeks after the formal opening of the William H. Coleman Hospital for Women, new unit of the Indiana University School of Medicine in Indianapolis, it was found necessary to place beds in the corridors to care for a few emergency cases. Since the dedication (October 20) of the new $350,000 unit, with a bed capacity of sixty-four, exclusive of nurseries, the hospital has been operated practically at full capacity, its service being restricted to obstetrical and gynecological cases. Records showed that at the end of the first five weeks 206 patients had been admitted to the hospital, and sixty-one others were receiving care in the pre-natal department as out-patients. Forty-one babies were born in the hospital during this time. The obstetrical, gynecological and pre-natal services of the Robert W. Long Hospital have been transferred to the new Coleman.

The hospital admitted eighty patients to the wards as free cases, with thirty-five as part pay and fourteen full pay patients, medical and surgical care being given without charge by the teaching faculty of the School of Medicine. Twenty-six patients were admitted who were able to pay a private physician for his services as well as for private rooms in the hospital. Patients were received from twenty-seven counties of the state, including Blackford, Boone, Brown, Clinton, Delaware, Fayette, Grant, Hamilton, Hancock, Hendricks Henry, Howard, Johnson, Marion, Madison, Miami, Monroe, Morgan, Owen, Porter, Putnam, Rush, Shelby, St. Joseph, Union, Vigo and Wayne.

Visiting physicians have expressed unqualified admiration and approval of the construction and equipment of the new hospital which was designed primarily as a teaching hospital. It is said to be one of the best examples of modern hospital construction and arrangement for obstetrical and gynecological work. The entire cost of construction and equipment, in excess of $350,000, was provided by Mr. and Mrs. William H. Coleman, of Indianapolis, as a memorial to their daughter, Mrs. Suemma Coleman Atkins.

The William H. Coleman Hospital for Women is located with other units of the Indiana University School of Medicine, including the Robert W. Long Hospital, James Whitcomb Riley Hospital for Children, medical school building and residences of the Training School for Nurses of the medical school, in a thirty-two acre tract on West Michigan street, extending northward to Fall Creek and the Indianapolis City Hospital and adjoining a 101 acre tract extending westward to White River, which is to be developed as a convalescent park by the Indianapolis board of park commissioners. It is immediately west of the Robert W. Long Hospital and east of the Ball nurses' home and training school now under construction, the half million dollar gift of the Ball brothers of Muncie. West Michigan and West Tenth street cars stop directly in front of the entrance.

The building has a frontage of 205 feet and is forty-three feet deep. It has five floors, three of which are used for patients, the ground floor being reserved for service units and the top floor for internes' quarters. The exterior is of Bradford red brick, with Bedford stone trim. Floors are of terrazo. Lighted and heated tunnels provide sheltered communication for transportation of patients, food and for communication with other units of the medical center. Robert Frost Daggett, of Indianapolis, is the architect, and Leslie Colvin, builder. Construction was begun in October, 1926. The building committee, which advised with the architect after a study and observation of the best practices elsewhere, was composed of Dr. S. E. Smith, provost; Dr. Charles P. Emerson, dean of the School of Medicine in Indianapolis; Dr. Arthur M. Mendenhall, head of the department of obstetrics; the late Dr. Orange G. Pfaff, who was head of the department of gynecology; Robert E. Neff, registrar of the School of Medicine and administrator of its hospitals, and Mr. Coleman.

At the main entrance of the hospital is a reception room, with a physicians' reading room adjacent. The main office opens at one side of the reception room and also into the corridor near the admitting rooms so that records or business matters pertaining to patients or visitors can be conveniently handled. Ward A, for gynecological cases, with sixteen beds arranged in cubicles of four beds each, with two semi-private rooms of two beds each, occupies the west end of the first floor, and on the east end are the two admitting rooms, out-patient pre-natal department with two examining rooms and laboratory, bath room and clothes storage for patients, offices of the social service department, chief resident physician, superintendent of nurses and housekeeper. An ambulance entrance at the rear opens into the admitting department, and there is a separate entrance at the east end for out-patients.

The second floor has twenty-two beautifully

furnished private rooms, and a fully equipped delivery room for private patients. On the third floor is Ward D at the west end, and the east end is given over to two surgeries, two delivery rooms, four scrub-up rooms, two labor rooms, and anaesthetizing room, sterilizer and preparation rooms, a physician's locker room, and a bedroom for use of physicians who might be detained on a case.

On each ward and the private room sections are utility rooms equipped with small sterilizers, and equipment for routine and emergency care of patients, with nurses' stations, drug cabinets, electric blanket warmers and other conveniences. Each floor has a food preparation room, which communicates by a service elevator with the tunnel to the central food kitchens in the Riley Hospital. Electric refrigeration is provided in the service rooms, food preparation rooms and laboratories. Nurseries with adjoining wash rooms are located on the second and third floors, and there is a separate small and completely equipped nursery for infectious cases.

Furniture throughout is of steel. Fixtures so far as possible are suspended from the walls, simplifying the problem of housekeeping and sanitation. Chutes lead to incinerators and linen rooms in the basement. An elaborate system of telephones, call bells and signal lights provides for communication within the hospital or with other units and with outside stations. Private room doors are wide to permit moving patients in their beds to operating rooms in emergency.

Dr. James D. George is chief resident physician of the new hospital, and Miss Hazel Deupree, R. N., is superintendent of nurses, with Miss Henrietta Davis, R. N., assistant superintendent. Pupil nurses of the training school for nurses of the medical school are receiving a part of their training in the new unit.

The Coleman hospital was the first in Indianapolis to add to its method of identifying babies a Bertillion print system. New born babies, before leaving the delivery room have their foot print recorded on a card, together with the mother's thumb print, and identifying data. This is in addition to the infant's name in a string of lettered beads about its neck.

At the formal opening exercises, October 20, the hospital was presented to the trustees of Indiana University on behalf of Mr. and Mrs. Coleman by Dr. S. E. Smith, and was accepted by James W. Fesler, president of the trustees. Dr. Emerson presided during the addresses made by Dr. Louis Burckhardt, and Dr. Charles E. Ferguson, professors emeritus of obstetrics, and the principal address by Dr. Palmer Findley, of Omaha, Nebr., president of the American Obstetrical and Gynecological Association. A memorial tablet to Mrs. Suemma Coleman Atkins in the hospital was unveiled by her son, Coleman Atkins. In closing, Dr. A. M. Mendenhall, head of the department of obstetrics, made a pledge that while the new hospital would be conducted for the better training in obstetrics and gynecology of the state's future physicians and nurses, that the welfare of the patients would receive first consideration. C. R. MACDONNELL.

CONJUGAL TUBERCULOSIS

Arnold Minnig, Denver (*Journal A.M.A.*, November 19, 1927), has reviewed 6,000 dispensary cases with reference to the incidence of tuberculosis in husband and wife. There were 1,888 married or widowed patients. Among these, there were 319 cases, or 16.8 per cent, in which both consorts had active tuberculosis or one or the other died of the disease. Of the 319 patients, 104 were widowed on account of phthisis. Of the 104, or 48 per cent, who were so widowed, fifty consorts had developed active tuberculosis. Of this 319, 181 were female and 138 male. The reason for the predominant number of females being infected may be explained by the fact that the wife is usually the nurse when the husband becomes ill. In other words, when there was a massive infection as occurs when one of the consorts died, one out of two developed the disease. These observations show something definite; viz., in a large number of cases adult infection is present and a danger. While not every adult who is exposed to tuberculosis is going to be infected, yet if he or she is below par, and the consort has open tuberculosis, there is one chance in six that the other is going to become infected. Also if the culture medium is good and the infection is especially massive, as in the case of a dying consort, the chances are one in two that the other will become infected. It was rather striking that of these 319 patients with conjugal tuberculosis only eleven were born in Colorado, and of these only five died of the disease, a forcible argument in favor of climate. Another aspect was whether, when the woman developed tuberculosis, the man remained faithful to his wife, and when the man developed tuberculosis, whether the wife remained faithful to the husband. In the greater number of cases the man was more faithful to his wife than the wife was faithful to the husband. Hygienic living and intelligent prophylaxis have a marked and evident beneficial effect. Tuberculosis in the mother is the most dangerous contact, and is the more frequent in marital tuberculosis. Whether one believes in exogenous or endogenous infection or both, proper prophylactic precautions must be observed. That each bacillus is to be feared is uncalled for because of the very strong natural immunity existing in man. Minnig feels now that sufficient data are at hand, that it is possible to announce that there is adult infection and that this conclusion should be propagated in an intelligent way through social agencies, the press, and the physician.

NECROPSY REPORTS ON PERSONS DYING SHORTLY AFTER EXTRACTION OF TEETH

The clinical-pathologic reports of three deaths, occurring within a short time after the removal of teeth, are presented by Richard C. Buckley, New Haven, Conn., (*Journal A.M.A.*, November 19, 1927), to emphasize again the dangers associated with the extraction of teeth. The first two cases illustrate the serious complications of extraction of many teeth in a patient whose general condition is poor as a result of an existing chronic disease. The association of acute infections and severe clinical symptoms in diabetes is well known. The second case represents a widespread cell degeneration which undoubtedly started following the extraction of a large number of teeth.

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EDITORIALS

THE IMPORTANCE OF BLOOD CHEMISTRY

Chemical analysis of the blood has been until just recently the toy of the bio-chemist in his experimental physiological laboratory. Thanks to the epoch-making work of Folin, and in turn Benedict, Van Slyke, Denis, Lewis, Myers, Fine and others, practical, simplified and accurate micro-chemical methods have brought blood chemistry to the very forefront of the medicine of today. Sufficient data has been collected to reveal the mechanism of many pathological processes and give a working knowledge to many others. The metabolic processes upon which depend nutrition, waste and repair are entirely chemical, and it is the function of the organs and tissues to carry out these chemical processes. Health prevails so long as these functions are properly performed, and it has become largely the domain of blood chemistry to estimate in disease the particular functions that are impaired, and to estimate the degree of impairment. Thus blood chemistry has become a routine in the clinical laboratory and part of the clinician's armamentarium, not for the ultra scientific study of rare and unusual conditions, nor for the particularly wealthy patient, but to be used in everyday practice. The simple fact is that blood chemistry examinations have become so important that the earnest clinician will use them routinely as frequently as he does the older, more familiar laboratory examinations, and almost as routinely as he does a blood count. Blood chemistry tells us what we are storing up or what we lack, what the kidneys and liver are doing; in fact, the exact status of carbohydrate and nitrogenous metabolism, giving us a solid basis for proper evaluation of urinary findings in nephritis and diabetes. The blood is the "common carrier" of the body and contains at all times a varying host of chemical entities having to do with waste and repair, and as time goes on future investigation will shed more and more light on functional disturbances, influencing the chemical balance of the fluids of the body.

While the proper performance of blood chemistry examination belongs to the clinical laboratory with its skilled chemists and elaborate equipment it is essential that the practitioner make himself familiar with the clinical application, proper methods of collecting blood and the interpretation and clinical significance of the findings. It seems well, therefore, to point out concisely the salient facts now of practical value. It should be remembered that, while the data from a single examination may be of great diagnostic value, yet it is not the occasional abnormality that counts so much as its persistence, and the persistence and degree of fluctuation from the normal can be determined only by repeated examinations. Just as we use the clinical thermometer and feel the pulse to determine daily abnormalities, so should blood chemistry variations be checked often. In blood chemistry quantities always are stated in milligrams per 100 c.c. of blood. Thus normal blood sugar is 70 to 125 milligrams per 100 c.c. of blood. In percentage of the whole blood these figures would read .070 to .125 of 1 per cent. Although more important than most examinations, blood chemistry does not replace or supplant other methods of clinical examinations such as urinalysis, etc., but goes hand in hand with them as an important phase of the clinical study. Since the composition of the blood is changed temporarily to marked extent just after a meal, the best time to obtain specimens of blood would be before breakfast or about four hours after a meal. For single determinations 5 c.c. of blood are sufficient, otherwise 10 to 15 c.c. should be drawn. The care with which the blood is collected and prepared has to do largely with accurate determinations. For example: for most purposes the blood should be fluid, so an anti-coagulant, sodium citrate, or potassium oxalate powder (fluid will dilute the whole blood) are used. If blood calcium is required, the oxalate would spoil this particular examination. If bilirubin content is wanted, hemolysis should be avoided and no anti-coagulant used. If a Wassermann test is desired, a separate specimen is necesary because of the anti-coagulant used in blood chemistry.

Among the most useful of these examinations are N. P. N. (non-protein nitrogen), urea nitrogen, uric acid and creatinin in studying kidney disease; blood bilirubin in liver and gall bladder troubles, hemolytic jaundice and pernicious anemia; blood sugar in diabetes; blood calcium in tetany and osteo-malacia; and cholesterol in gall stones. In renal disorders the best single test is blood urea. In the nephritides, the severity of the case may be measured by estimations of the various nitrogenous elements. Uric acid is first to increase, so when traces of albumen and casts are found look first for increased uric acid. In established cases of nephritis, as the case becomes more severe the N. P. N. urea and creatinin increase markedly. When urea nitrogen is around 100 mgs. or over, coma is imminent. High creatinin values indicate a terminal nephritis, prognosticating early demise. In coma of unknown origin normal urea values would exclude uræmia and vice versa. In gout N. P. N. and urea are

normal, while uric acid is increased. In non-gouty arthritis N. P. N. and urea are increased while uric acid is normal.

Thus in renal disease blood chemistry serves as an efficient and reliable index for diagnosis, prognosis and treatment: it differentiates between uræmic and other comas, and between gout and arthritis. In gall stones cholesterol is increased, and in tetany and osteo-malacia calcium is decreased. When we find sugar in urine the question is whether it is the result of excessive sugar ingestion, resulting in an overflow through permeable kidney barriers (renal diabetes) or of an intrinsic disturbance of carbohydrate metabolism (a true diabetes). If blood sugar is normal in the presence of glycosuria it is a *renal diabetes*. If blood sugar is increased, whether there is glycosuria or not, it is *true diabetes*.

To thoroughly understand disease it is necessary first to understand the normal physiology and chemistry upon which normal functions depend, next the manner in which these functions may be interfered with, altered or destroyed, and lastly, the significance and rationale of the methods used to determine the existence and measure the degree of function disturbance. This is best done by routine use of blood chemistry.—B. W. R.

PROGRAM FOR MILK CONTROL

The need for a definite program of milk control in Indiana has been met repeatedly for several years. The establishment of the Central Milk Laboratory partially fulfilled this need. However, under the present program, field inspection of the source of contact between the laboratory and the cities and their milk supplies has been insufficient. It has been necessary to depend upon the State Food and Drug Inspectors, a few local food inspectors, and the local health officers to carry on the control in the field. This plan is not successful because the milk control work is such that the full time of the men is required. Many other activities prevent full time being given to the milk program.

The importance of proper control of city milk supplies is never questioned. It has a very definite and important place in food inspection. Many states are carrying out intensive programs and have dairy inspection forces. Indiana should be among these states.

With the need and importance of milk control in mind, the following program has been offered by the State Health Department:

1. The employment of at least one, preferably two or more, dairy and milk inspectors.
2. The duties of the inspector or inspectors to be confined to dairy and milk inspection.
3. The powers and duties of the milk and dairy inspector to be the same as that of the present food and drug inspectors.
4. Definite and systematic studies to be made of the milk supplies of Indiana cities.
5. These studies to be accomplished by the inspector visiting a designated city and acquainting himself with the characteristics of the milk supply, its source, method of handling, sale, etc.
6. A series of at least three samples of milk from each supply to be submitted to the State Laboratory for examination as specified in the "Standard Methods of Milk Examination" of the "American Public Health Association."
7. The laboratory reports on milk to be followed by inspection of the dairies and milk plants.
8. The laboratory and field forces to work toward the passage of milk ordinances in these cities which are interested.
9. The field force to assist local inspectors and health officers with difficult problems and special investigations pertaining to the milk supply.
10. The general State Food and Drug Inspectors to continue the regular sanitary inspection of milk plants and other dairy products manufacturing plants.

With the program in effect as outlined above, a more far-reaching, systematic and progressive milk control can be accomplished. It is impossible to think that all of the milk supplies in the state can be controlled in this manner. The work when instituted will undoubtedly create interest over the state and cause more cities to take an active and self-directed part in the control of their milk supply.

MEDICAL ENDORSEMENT OF CIGARETTES

We have had occasion to condemn the attempt on the part of the manufacturers of a well-known cigarette to make it appear that any considerable number of medical men are endorsing a particular cigarette as less injurious to the throat than any other cigarette. In the first place, we do not believe and we feel satisfied that it cannot be proved that any one cigarette, no matter what it is, is any better than any other insofar as its effects upon the throat is concerned. In the second place, we desire to stiffen up the backbones of a lot of spineless physicians who seem to be bought by a carton of cigarettes, or perhaps unduly influenced to testify to the virtues of any particular cigarette. Now comes a letter from the *Medical Review of Reviews,* presumably sent to the offices of all state medical associations, and received by the office of our Association, which reads as follows: "We beg to call your attention to a matter that has excited some comment among the members of the medical profession, namely the attempt on the part of the manufacturers of a certain brand

of cigarettes to give the public the impression that the physicians of this country endorse any one cigarette preferentially on a basis of healthful properties.

"We believe as do a great number of leading physicians throughout this country with whom we have communicated, that this practice is pernicious and undermines the public's faith in the disinterestedness and honesty of the medical profession. In pursuance of this idea, we have communicated with a large number of physicians and have asked them the following two questions: The first was, 'Do you not agree with us that it is impossible for one cigarette to have any advantage over all others in regard to throat ease or irritation?' to which the answer was almost unanimously 'yes.' The second was, 'Is it not your observation that there is no scientific reason for preference for any given cigarette and that any preference is on a taste basis?' to which the answer was almost unanimously 'yes'.

"On the other hand, the advertisements which you may have noticed throughout the country claim that the endorsements which this company has received for this particular cigarette represent the authentic voice of the 140,000 physicians of this country.

"We ask, therefore, that in your capacity of leading officer of your state medical society you ask the physicians of your state to pass a resolution against this type of advertising. We ask that this resolution be so worded that it will endeavor to put to an end the practice of manufacturers securing medical endorsements and making them, by implication, wholly authoritative."

We are wholly in sympathy with this program, for we think it is time to call a halt upon the scheme of making the medical profession the cat's paw of cigarette manufacturers in exploiting their product in a manner that is not justified by the facts.

SELECTION OF OFFICERS FOR A MEDICAL SOCIETY

The election of officers for a medical society is more important to the welfare of the organization than it is generally given credit. It appears that the traditional attitude towards an office, especially the president, calls for the election of a man of advanced years who has passed his years of greatest activity and because of past service is entitled to the compliment of an election as president. This is the wrong basis upon which to elect officers of any working organization. If our medical societies wish to prosper they will elect active, enthusiastic men as officers. It is a working job and not an honorary one, and when a man is elected to such a position he should regard it as a commission to work for which the society has chosen him, and not as an honorary compliment. Every organization has a personality which is a composite of the personality of its membership. The qualities of its character are greatly influenced by the type of leadership which it elects. Enthusiasm is the quality most essential to success. It follows that if a medical society wishes to prosper it will elect for its active officers men who from past performances in the society have demonstrated their enthusiasm by an acute interest in the welfare of the organization.

THE WOMAN'S AUXILIARY OF THE AMERICAN MEDICAL ASSOCIATION

At the 1922 session of the American Medical Association, held at St. Louis, a woman's auxiliary to the American Medical Association was organized, with nine states enrolled. In less than four years twenty-seven states already have organized state auxiliaries and Indiana is among the number. It is announced from the national headquarters that where there is a county medical society there should be an auxiliary. It has been noted that there is more interest and enthusiasm and a greater spirit of comradeship among the members of the county medical society if there is an active auxiliary working in the community.

The object of the woman's auxiliary is to be all that its name implies, or an aid or reserve force, organized for the purpose of responding to any call from the medical profession. Among the most specific purposes are mentioned the following: Do all the work assigned to it from time to time by the American Medical Association; to promote closer social contact between the families of physicians; to assist in lightening the burdens of humanity; to help preserve the health of the people. It is the earnest endeavor of the auxiliary to bring its work to the attention of all interested in the welfare of our people. Every physician's wife should feel it a privilege as well as her duty to promote dependable health education, and not leave it in the hands of those interested in spreading the propaganda of the various cults. She can aid materially in the auxiliaries' efforts to impress upon all club members a proper conception of the real mission of organized medicine, especially in its crusade of preventive medicine. She may gain much from her club activities, but she can give even more to her club co-operating with the auxiliary in its health education program.

Among the specific things recommended for state and county auxiliaries are mentioned the following. To outline health programs to be presented before other organizations; to secure if possible moving pictures to illustrate the importance of the annual physical examination of each member of every household, servants included, by the family physician; to recommend to all clubs

that they place capable physicians' wives in charge of club health departments in order to secure authoritative programs; to assist in providing health talks over the radio by prominent physicians and health officers—these speakers should be appointed by the county medical society; to continue efforts to place *Hygeia* in every home, as it is the leading health magazine of the United States and is published by the American Medical Association; to suggest *Hygeia* subscriptions as Christmas gifts and also as a gift for the expectant mother for the helpful, healthful suggestions she finds in *Hygeia* are more lasting than perishable flowers or unbreakable toys.

Among some of the social activities recommended to county auxiliaries we note the following: When the medical society wishes some prompt service from the auxiliary the telephone committee can get the information to the entire membership within a few hours. The courtesy committee calls upon the wives of physicians soon after the husbands become members of the county medical society. If a member is ill or bereaved this committee lends its sympathy and service. Visits are made also when out of town physicians' families are ill in local hospitals. Courtesies are extended to wives of physicians while they are visiting in the city. Arrangements are made for receptions, teas, and other entertainments where the wives of physicians may become better acquainted. It is suggested that near the holiday season an evening affair may be given in honor of the president and officers of the county medical society. When there is a state or national medical convention the entertainment committee co-operates with the county medical society in providing entertainment for the visitors.

The philanthropy of the auxiliary consists in visits to the charity wards of the hospitals, taking fruits, flowers, etc., and books and toys to the children. Showers of linen and clothing are given for the babies in the hospitals, and medical dressings and aprons for the doctors and nurses in their charity work; gowns and bed jackets for tuberculosis hospitals are provided, and visits are made to institutions for the aged, furnishing them with entertainment. Soldiers, old and young, are provided with games, radios, victrolas, edibles, automobile rides, Christmas trees, etc. A milk fund is provided for undernourished school children, and healthful school luncheons are prepared and served to school children at a minimum cost. First aid tents are furnished the Boy Scouts, and rest tents for Salvation Army camps. Stockings are filled and sent to the Empty Stocking Crusade, and Christmas Boxes are furnished the Salvation Army for distribution. Donations are made to the Community Chest and loans are made to needy families.

In the matter of education the auxiliaries outline campaigns for securing birth registration; co-operate with Chambers of Commerce in their health programs, and interest boys and girls in giving health plays in school; co-operate with health officers in their work, especially in rural districts, and furnish good speakers to go before clubs to present health programs with moving picture illustrations. The auxiliaries in their regular programs discuss health laws pertaining to county and state, what constitutes pure drinking water, food and sanitation, midwife problems, history of medicine, the lives of great physicians, and the history of the American Medical Association.

It is pointed out in the circulars concerning the auxiliary that the organization must avoid participation in any kind of politics of whatsoever nature except upon the recommendation of the local county and state medical organizations, or the American Medical Association.

In Indiana the Woman's Auxiliary but recently started has been very active, and already there are organizations in many counties of the state. It is hoped and expected that no county in the state will be without its auxilary to the county medical society, and the movement deserves encouragement at the hands of medical men individually and collectively. The president of the Indiana Auxiliary is Mrs. Frank W. Cregor, of Indianapolis; the president-elect is Mrs. W. R. Davidson, of Evansville; secretary, Mrs. A. C. Clauser, Delphi; and treasurer, Mrs. O. T. Scamahorn, Pittsboro.

THREE STRIKES AND OUT

It's three strikes and out in every case of delinquent medical dues.

First, your name is struck from the county medical society roster.

Then your name is struck from the society rolls and THE JOURNAL mailing list.

The third strike comes from the files of the American Medical Association.

All that happens if you neglect to pay your medical society dues before February 1, 1928. The American Medical Association estimates that it costs almost $1.00 to reinstate each delinquent member.

Here in Indiana we are very liberal toward delinquents. Most state medical associations declare a man delinquent if his dues are not paid by January 1 of each year. In Indiana a man is given twenty-eight days of grace and is not declared delinquent for non-payment of dues until after February 1.

So let's each of us "crash through" with our medical society dues right away so there will not be any strike outs this season. TOM.

CORRESPONDENCE SCHOOLS FOR NURSES

"IN these days of predigested food, self-propelling vehicles, nickel-in-the-slot lunch rooms,

and mail order department stores, it is not surprising to find misguided persons who think they can learn anything at home. The mail order medical school has disappeared from the horizon, though no doubt some of the medical cults still may be studied in colleges where a postage stamp is the matriculation card. The nursing profession also struggles sadly against the efforts of eight or more concerns that purport to teach the principles of nursing technic by this somewhat circuitous method. One school, of which the dean is both a "D.O." and a "D.C.P."—and the first letter presumably stands for "doctor"—makes the following simple assertion:

"Our perfected system makes it possible for the woman with only a common school education to master the essential principles and methods of nursing without giving up her work or leaving home. The essential material is condensed into 24 lessons, and many students study only these lessons, using the text books for reference, or for occasional reading.

"We wish to particularly caution you not to get the idea that your preparation for the practice of nursing means long hours of tiresome, unnecessary study, or b o r e s o m e , disagreeable work. . . .

"This course is being given at an introductory price of $70.00, or $57.00 for cash."

When the courses are completed, the aspirant to the practice of nursing receives a "handsome lithographed diploma" and the title of "graduate nurse." This should be a great help to her, considering that she must still persuade the state board of her qualities and qualifications if she wishes to be a registered nurse, or a physician and his patients if she wants a job. Unfortunately, the catalogues of some of these alleged schools cite as references the names of physicians who have no doubt thoughtlessly contributed testimonials or aided in preparing literature. Any doctor knows that the practical procedures in care of the sick and the interpretation of the significance of the nurse's observations are not to be learned in twenty-four lessons, and certainly not without bedside instruction. The persons most seriously harmed by correspondence courses in nursing, after the simple-minded woman who pays her money for the instruction, are the patients who depend on the nursing and the physician who is willing to submit his reputation to such utterly incompetent assistance."—*Journal of the A.M.A.*, April 2, 1927.

The above is a discussion of a subject that first received attention in an editorial entitled "Correspondence Schools for Nurses" which appeared in the *Journal of the A. M. A.*, May 31, 1913. Despite all the publicity given this matter in medical journals and periodicals relating to nursing, an effort still is being made to dupe women into giving up a large fee for so-called correspondence courses in nursing. A recent claimant for business is the Academy of Nursing having an office in the Medical Arts Building at Fort Wayne, Indiana. This enterprise is run by a man named Zimmerman who formerly was connected with a regular correspondence school. So far as known, neither Zimmerman nor his one office girl knows anything more about nursing than a rabbit, yet he is attempting to secure students, and either he or his representative is reported as having been in the northern part of the state securing one hundred dollars in advance from credulous women who evidently think they will be made full-fledged nurses by the correspondence method. Of course, as pointed out by the *Journal of the A. M.A.*, these correspondence nursing schools are fraudulent in that they cannot give adequate instruction in nursing by the correspondence method. In other words, it is another easy way to make money, and physicians of Indiana should make an effort to prevent credulous young women from taking up with any scheme of that kind.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

BROADCASTING stations still continue to broadcast medical buncombe over the radio. Is there no way to stop this imposition upon the public?

"THE Chicago Medical Society recently has taken the stand that free medical service is to be rendered only to those who are recipients of other forms of charity. At last we have found a group of doctors with sense."—*Southern Medicine and Surgery*

THE first man to pay his dues for the year 1928 was S. S. DeLancey of Williamsport, Indiana, a member of the Fountain-Warren County Society. His dues were sent in along with fourteen other members of the Fountain-Warren County Medical Society on December 2.

IF you don't pay your taxes on time you are penalized by the assessment of an extra amount which must be paid. Wouldn't it be a good idea to make physicians pay an extra sum if they become delinquent in the payment of their medical

society dues? We are in favor of putting the plan into operation.

THE application of a solution of pituitary to the nasal mucous membrane as a means of induction of labor has been reported in the *Journal of the A. M. A.* The procedure is reported to have been successful in every one of fifty-six cases in which it was used. Perhaps this is another one of those things that will be mis-used by the unscrupulous.

OUR congratulations go to Dr. Anita Muhl, a graduate of the Indiana University School of Medicine, with the addition of Ph.D. in psychiatry from the George Washington University, who recently has been made chief of the department of special education in the State of California. She has been especially successful in psychiatric research, and numerous valuable articles from her pen have appeared in scientific publications.

IF anyone doubts what postgraduate work can do to build up the county medical society let him read the reports of the councilor for the fifth district, published in this number of THE JOURNAL, in which he says that postgraduate courses started in Vigo county with an attendance of fifteen or sixteen at each meeting and now there is an average attendance of more than fifty. What has been accomplished in Vigo county may be accomplished in any other county in the state.

COUNTY medical society secretaries in Indiana are herewith reminded that we desire condensed reports of county medical society meetings for publication in THE JOURNAL. We also desire to remind all of the readers of THE JOURNAL that we are anxious to secure personal and news notes of general interest to the profession. Then there is the department devoted to correspondence, which we shall consider an open forum for the expression of views upon any topic that may be of interest to the readers.

GEORGE EASTMAN, multi-millionaire bachelor of kodak fame, has given millions of dollars for the establishment and maintenance of various institutions, located in his home town of Rochester, devoted to literature, art and science. The buildings devoted to medicine and surgery, dentistry, music and the arts are models of their kind and are unexcelled in efficiency. What a pity it is that more of our very wealthy men do not find pleasure in devoting at least a small part of their fortunes in a similar way!

THE American Society for the Control of Cancer is conducting an educational campaign in the lay press concerning the methods of preventing as well as recognizing the early signs of cancer, and the necessity for seeking competent medical advice immediately upon the appearance of cancer symptoms. This work should receive the encouragement of departments of health and state and county medical societies, for the public deserves to know something about the latest and most effective means for the diagnosis and treatment of cancer.

AT Richmond the Y. M. C. A. is said to be influenced to an unwarranted extent by an off-color physician who is not a member of the county medical society but stands well with the Y. M. C. A., churches and similar organizations through handsome donations, and at a so-called health meeting sponsored by the Y. M. C. A., he took occasion to circulate Koch Cancer Cure propaganda. What has occurred in Richmond is very apt to occur in many other sections of the state. Such efforts to spread dangerous propaganda should be suppressed and the exploiter discredited.

SOME of the physicians' supply houses, or notably the firms selling surgical instruments and appliances, are advertising physiotherapy courses. The trouble with most of such courses is that they are given for commercial reasons and emphasize the commercial phase of physiotherapy. There is no question but that physiotherapy deserves more consideration than some of us have been giving it, but discussion of the subject should come from conservative medical men whose opinions are fairly trustworthy, and not from salesmen and medical dupes who are talking up physiotherapy because they get paid for doing it.

WITH the beginning of the New Year, each and every one of us should decide to be a booster and not a knocker. This applies with especial force to those who either have been weak in their allegiance to our State Medical Association or are fighting some of its policies. Constructive criticism is welcome, but carping criticism is the weapon of a disturber who is more interested in tearing down than in building up. There is too much back-biting and jealousy among individual physicians. Oftentimes they are too suspicious of one another. If they would follow the rule of not saying anything when they cannot say something that is good, the path of every physician would be smoother.

THE Third Race Betterment Congress was held in Battle Creek, Michigan, the first week of this month. The conference extended throughout an entire week and a program was presented by some of the leading scientists, educators, and others who discussed ways and means of applying science to human living in the promotion of longer life, increased efficiency, well being, and of race development. Never have we seen a program that had so much real meat in it from beginning to end, and furnished throughout by such

a galaxy of noted scientific men and educators. We hope that many of the papers and addresses delivered at the conference will be made available for all to read.

IN Chicago a layman who has been associated with window washers, picture hangers and janitors, proposed to organize an economic league for physicians and surgeons, the purposes of which, as announced, are to correct the abuses of medical charity, to eliminate difficulties of collection, and to interfere with the progress of state medicine. Physicians are asked to pay an initiation fee of five dollars, and two dollars per month subsequently. It is fair to assume that the league is planned primarily for the benefit of the organizer. At all events Chicago doctors are not taking very kindly to the enterprise, and are wise to keep their hands off. Likewise physicians in other states will be wise if they turn down any proposition to organize an economic league.

TOO much cannot be said in condemnation of the practice of some physicians in prescribing mixtures the composition of which they do not know. At this time of the year manufacturing chemists and even drug stores are encouraging physicians to prescribe proprietary analgesic tablets of one kind or another in the treatment of colds, discomforts of menstruation, neuralgias, rheumatism, etc. Unless these analgesic tablets under a proprietary name have been passed upon favorably by the Council on Pharmacy and Chemistry of the A. M. A., it is a good plan to let them alone. Publication of the formula means nothing, for it is a well-known fact that a large number of manufacturing chemists lie like turnip thieves when they talk about the formulæ of some of their pet proprietary remedies.

HYGEIA is responsible for the statement that a powder puff, no different than that used by hundreds of thousands of girls and women, through examination in the bacteriological laboratories produced twenty thousand bacteria clinging to it and ready to be applied to a clean face. Many of the bacteria were harmless, but some were the type that could have played a part in an infection. It is pointed out that through this source many skin diseases that are disfiguring and embarrassing are due to lack of proper cleansing of the powder puff. However, it will be a difficult task to prove to the average female that a perfectly clean powder puff is an accessory that will yield rich dividends as compared to the dirty powder puff.

WE always have felt that there would come a day of reckoning, with painful experiences, in consequence of our American habit of buying upon the installment plan. Now we learn that one of the representatives of the British government is warning the British public concerning the danger of the habit of installment buying which seems to have been growing in proportion in the United Kingdom during the last year or two. Installment buying is called a "trade built upon sand," and in the end will prove disastrous. In America the great middle class has mortgaged incomes of the future, and eventually someone's fingers are going to be burned in consequence. However, as we already have advocated, if this installment buying is to continue, the physicians of the country ought to make some arrangements for getting their compensation from the great middle class in installments rather than not get it at all.

A magazine called *"Babyhood"*, having its office of publication in Marion, Indiana, so far as we can learn has no medical men on its editorial staff. The enterprise seems to be a purely commercial one, and this appears to be all the more patent when one scans the pages of the periodical, and especially the advertising pages which are loaded with what physicians call "rotten" advertising. However, we learn that recently the management has decided to conform to medical standards, and is trying to improve upon the editorial talent as well as the policy to be followed in the acceptance of advertising and in procuring and printing contributions. We congratulate the owners upon taking this stand and we shall be interested in noting how sincere they are in their efforts to produce a magazine that reputable physicians can endorse. The enterprise will have our approval and support when it cleans house.

A VERY energetic effort must be made to prevent the New England Anti-vivisection society from securing a law, applicable to the District of Columbia, that will prevent animal experimentation. The idea is to secure a federal law from congress that will apply to the District of Columbia, but such a law, as the anti-vivisectionists well know, would be an entering wedge for state legislation of a similar character. Every physician should make it a point to acquaint his congressmen and state senators concerning the dangers of such legislation, and its effect in retarding medical progress. Emphasis should be placed upon the fact that no great medical discovery has been made in connection with the prevention and cure of many diseases that has not been brought about through information secured by animal experimentation. At the present time vivisection is surrounded with restrictions which make it humanitarian.

SOME physicians make it a practice not to

charge clergymen. We wonder if this isn't done with the idea of buying the good opinion and the recommendation of the clergyman, or perhaps because it is a good advertising proposition. If so, a physician is guilty of bribing, and the clergyman is guilty of accepting the bribe on the tacit understanding that if payment is not given in money it must be given in something else. Clergymen are better paid than they were a few years ago, though unquestionably their salaries even today are small compared with the incomes of those following other pursuits. However, there is no more reason for wholly donating services to a clergyman than to a lawyer, a merchant or a mechanic. The bill for professional services should not be made burdensome but should be consistent with the ability of the clergyman to pay. By so doing the clergyman is placed upon an independent basis and he does not lose his self-respect.

IF any member of the Indiana State Medical Association does not read "Truths About Medicine" published in every number of THE JOURNAL, we believe that man is behind the times and does not make use of valuable information that is furnished him every month in a condensed and readable form. Not only does this department give a list of the New and Nonofficial remedies that have been investigated and have proved to be worthy of acceptance by the medical profession, but it contains a section called "Propaganda for Reform" which exposes the falsity of the claims put forth by various manufacturers and individuals who are attempting to exploit the medical profession and the public through the sale of worthless or near worthless medical frauds of one kind or another. We suggest that every practicing physician in Indiana read carefully this department, for the information contained therein will be found thoroughly trustworthy and a guide to the busy practitioner of medicine.

RECENTLY we have learned that a podiatrist by the name of Crane, practicing in Elkhart, made an appointment with a patient for a surgical operation to be performed under a general anesthetic. A regular physician refused to give the anesthetic and induced the patient to seek advice from a medical man. The prescription blank of the podiatrist has the following heading: "Dr. Crane, podiatry surgeon and physician." The American Medical Association directory does not list Crane as a physician and surgeon so we have some doubts about his having studied medicine and surgery and he certainly has no right to advertise as such nor, unless we are much mistaken, has he any right to use the term "Dr." in connection with his podiatry work. The strange thing about the whole business is that regular physicians will refer surgical cases to podiatrists. It is a good deal like the regular physicians referring their malignant cases to a cancer quack, and the latter is what is being done right here in Indiana.

A correspondent in one of our Indiana newspaper offers a suggestion to the anti-vivisectionists that is not entirely without merit and no doubt many people would like to see it adopted and carried into effect. It is that some such brutal murderers as Hickman, Loeb, Leopold, and many others of their kind, justly sentenced to electrocution or confinement for life, should be turned over to medical societies for experimental purposes in the interests of scientific advancement. It would be better, it is argued, to perform medical and surgical experiments upon the human being than upon guinea pigs, monkeys or other animals, so why not put these criminals to some useful purpose instead of electrocuting or hanging them? Perhaps the only fear to be encountered is that some experimenters, having a wholesome detestation of such fiends as Hickman, would be tempted to carry out experiments that would be far more painful than death in the electric chair. We confess that hanging, electrocution, or life imprisonment is light punishment for such fiends as those mentioned.

THE secretary of the New York State Board of Health says that diphtheria cannot be eradicated until the family doctors accept the responsibility of advising preventive treatment of the disease for the babies and young children. As an easy and dignified way to do this without offending patients and without attaching to the physician any stigma of unethical conduct, slips are provided by the Board of Health for the use of physicians as inserts in letters or statements to the patrons. These inserts, a suggestion for our own Indiana State Board of Health, read as follows:

IF YOU ARE A PARENT

Have your children permanently protected against diphtheria simply and safely.

The method—three injections of toxin-antitoxin.

The time—as soon after the age of six months as possible.

Don't let delay make you a prey to future regrets.

New York State Dept. of Health
Matthias Nicoll, Jr., M.D.
Commissioner

A MAN styling himself Dr. William A. Oyler is going over the country soliciting funds from physicians on the plea that he formerly practiced at Cicero, Indiana, had bad luck through sickness and the loss of his property, and now wants to obtain sufficient money to enable him to start in practice again. An inquiry addressed to

a reputable physician of Cicero is answered as follows: "A physician by the name of Oyler, giving his address as Cicero, for a number of years has been going around over the country begging of physicians. I have received letters from a number of places making inquiry about him. He never had an office here, never practiced here, and I don't think he wants to practice anywhere. He has adopted an easy way of making a living and I think he intends to keep it up. In my opinion he is not deserving of help, for so far as I know he has never met with any misfortune. He does not confine his begging to Indiana." Not once in a thousand times is a begging physician deserving of the slightest consideration. We believe that the physicians in any community will take care of the deserving members of the profession in that community.

CONGRESS is in session and in all probability some of the proposed legislation would, if enacted into law, affect medical practice in one way or another. Among legislation that will be sought will be a law preventing the use of animals for experimental purposes. Perhaps the anti-vivisectionists will be satisfied with the bill that prevents the use of dogs for experimental purposes, and if they get that through then they will try to have the law include guinea pigs, rats, mice and all other animals. Physicians individually and collectively should make an effort to prevent the enactment of any legislation that will retard scientific advance, and it is a well-known fact that animal experimentation has been the means of bringing about most of our great discoveries in medicine and surgery as well as veterinary practice.

An effort will be put forth at this session of Congress to continue federal activities under the Sheppard-Towner Maternity and Infancy Act after the expiration of the period in which such activities are now limited by law. The American Medical Association, through its House of Delegates, has gone on record as absolutely opposed to this act, and the reasons for it have been given time and again in the medical professions of the country. The medical profission is just as much opposed to the continuation of the act as it was to the passage of the act originally.

The Journal of the A. M. A., in answer to an inquiry, says that the coal-tar anodynes have relegated the opiates to a secondary place as they relieve many varieties of pain for which opiates formerly had to be used. One of the coal-tar anodynes, amidopyrine, (pyramodyne) probably has the highest analgesic value as compared to toxicity. In combination with other reagents, especially phenobarbital, (luminal) increases the analgesic power to a considerable degree. In colics anti-spasmodic agents such as those of the atropine series may be added to advantage. Codein, though moderately analgesic when given by itself, also seems to increase the efficiency of amidopyrine in the treatment of pain. To illustrate the manner of prescribing the combination of these agents, a prescription as follows is recommended:

℞ Extract of hyoscyamus.....0.15
Codeine phosphate 0.30
Phenobarbital 0.30
Amidopyrine 3.00

Mix and divide into fifteen capsules.

Label: One every hour until relieved or until three are taken; then every two to four hours as required.

It is not always necessary to use all four ingredients, but by some such combination it is frequently possible to secure relief from pain without having to take recourse to the use of morphine.

DR. T. O. GASAWAY, 1108 Central Avenue, Indianapolis, a so-called cancer specialist, has been accused of charging $740 for one radium treatment of a patient having an incurable cancer of the tongue, and having executed an agreement with the patient to the effect that not only would the one treatment cost $740 but that all subsequent treatments were to cost $150 each. The patient's relatives had to borrow the money to pay the extortionate charges made, and now are putting up a complaint, in view of which Dr. Gasaway refunded $240, making the net cost for the first treatment $500. The relatives have executed a sworn statement concerning the transaction, and the same has been turned over to the Better Business Bureau of Indianapolis for such action as seems indicated. The fee exacted in this particular case is nothing short of deliberate robbery. So far as we know there isn't a reputable or trustworthy physician who would charge $740 or even $500 for one treatment with radium, but the so-called cancer specialists, most of whom are the worst type of quacks and imposters, have taken advantage of whatever popularity radium may have gained in the treatment of malignant diseases and made their dupes pay extortionate fees for so-called radium treatment. In many instances the cancer quack does not possess any radium but makes a bluff and charges all that the patient will stand. We have been told that there are some physicians in Indiana who are referring their supposedly malignant cases to Dr. Gasaway for treatment. The incident to which we have called attention ought to prove to Indiana physicians that Dr. Gasaway is not the man to whom patients should be referred.

IF any member of the Indiana State Medical Association thinks that it doesn't mean anything to become delinquent in the payment of his dues

let him ponder over this actual occurence in one of our sister states, and it is an occurence that could happen in Indiana very easily. A well known and busy physician neglected to pay his dues until April when they should have been paid prior to January 1st in order to avoid delinquency. While delinquent, or during the time elapsing between January 1st and the payment of the dues in April, the delinquent physician rendered services to a patient who afterward sued the physician for malpractice in connection with the services rendered. It cost the physician fifteen hundred dollars to defend the suit, and his troubles are not ended yet. All of this expense would have been borne by his state medical association had he not been delinquent in the payment of his dues. In short, a delay of a few weeks in the payment of medical society dues already has cost him fifteen hundred dollars and is very apt to cost him more. This is exactly what can happen in Indiana at any time, for there are many physicians in Indiana who are either careless or indifferent about the payment of medical society dues, and some of these days one or more of those men are going to be caught with a malpractice suit based upon services rendered during the period of delinquency, and under those circumstances the expense of defending the suit will fall upon the individual physician and not upon the Association. The dues to the Indiana State Medical Association become delinquent upon February 1st, and on and after that date delinquents are *not* entitled to medical defense. A word to the wise should be sufficient.

TRADE statistics show that during the last year the female of the species in the United States spent thirty million dollars more for silk stockings alone than the male of the species for all items classed under the heading of haberdashery. Well, why shouldn't they? Legs are the most conspicuous part of the female today and they look just a little bit better if they are "dolled up" some, even if covered with nothing more than the gauziest kind of silk hosiery. As an evidence that legs are the thing that count in this world McIntyre is responsible for the story that the photographers for the New York newspapers will not take the pictures of female celebrities unless the latter will consent to pose with as much of the legs exposed as possible, for as one newspaper photographer said, "Lady, legs are the thing that the public wants nowdays, so show 'em up." However, from another standpoint, the prevailing styles have been the means of showing up some misshapen and ugly looking knees and calves of the females, and if some of the knock-kneed and spindly legged girls knew just how ludicrous they look they certainly would foreswear short dresses. But, oh, boy, how some of the dead and gone admirers of the female form would have been pleased to have lived in this age when he looks at some of the beauties! The sophisticated men of this age who are surfeited with the views look upon beautiful female legs without an increase of a single heart beat, and we physicians look at the women of today who go so nearly undressed in zero weather and wonder why they do not freeze to death or die of pneumonia. Cold and uncomfortable? Of course the dear things are! But it's style, and if style kills them they die happy. We poor worms of men, groveling in the dust at the feet of these temperamental and slavish followers of fashion are frozen to the marrow of our bones in winter if we are not clothed in our "heavies" that extend clear to our ankles, and our legs to the ground encased in heavy woolen trousers. But then, man was not born to suffer, and he loves comfort, whereas you take the very joy out of life if you take away suffering from a woman! She really isn't happy unless she is suffering, either mentally or physically, but Lord bless them, how we do love them even when they are suffering!

PHYSICIANS should take a hand in politics insofar as it concerns the election of aspirants for office who are in sympathy with the aims and objects of the medical profession. From time to time we shall be specific in calling attention to the qualifications of some of those holding public office. Right now we desire to call the attention of the physicians of the twelfth congressional district to the fact that the present congressman, David Hogg by name. who seeks renomination at the hands of the republican party, is reported to have made publicly some insinuating and damaging remarks concerning the medical profession, and as an attorney he has defended in court one of the worst medical imposters who has been condemned openly by the Better Business Bureau of Fort Wayne and also exposed by the newspapers as deluding and swindling the ignorant and the poor through a pretense of curing their various ailments by a species of legerdemain. One of the numerous methods pursued in order to bleed susceptible people is to make the sign of the cross with iodine on the skin under the chin for the cure or relief of goiter. Other equally absurd and ridiculous practices are indulged in to delude those who come for relief. It is such an impostor that sought and secured the services of Representative Hogg at a time when it was doubtful if any lawyer worthy of the name in the twelfth congressional district would defend such a case.

It is Representative Hogg who is accepting invitations to occupy the pulpits in various churches throughout the district to advertise himself and curry favor among church-going people. To our notion it is a small bore politician who will prostitute the churches for his own selfish ends, and

to paraphrase an expression of Trader Horn, we have no use for any man who is nudging the Almighty with the idea of obtaining personal favors. To disabuse the minds of any of the readers of The Journal as to the possibility of partisan politics entering into this criticism we frankly state that we are counted as republican and voted for Representative Hogg at the last election. Furthermore, Representative Hogg never has, so far as known, been guilty of offending us to the slightest extent, except as his conduct which calls forth this editorial note has created disapproval. The point of the whole discussion is that physicians who are in their right minds will not support for a political office a man who speaks disparagingly of the regular medical profession and is known to be a friend of quackery and medical charlatanism.

DEATHS

Tillman O. Armfield, M.D., of Elwood, died November 18, aged seventy-three years. He graduated from the Detroit Medical College in 1881.

Charles W. Mackey, M.D., aged sixty-nine years, died at his home in Portland, November 26, 1927. Dr. Mackey was a member of the Jay County Medical Society, the Indiana State Medical Association and a fellow of the American Medical Association. He graduated from the Medical College of Ohio, Cincinnati, in 1881.

Charles M. Coggins, M.D., of Snoddy Mills, died November 30th, aged seventy-four. He was a graduate of the Medical College of Ohio, Cincinnati, in 1876.

George E. Reynolds, M.D., of Columbus, died December 28, aged seventy years. Dr. Reynolds graduated from the Medical College of Indiana, Indianapolis, in 1881.

Walter A. Hager, M.D., of South Bend, died December 6, aged seventy-four years. Dr. Hager was a member of the American College of Surgeons, the American Academy of Ophthalmology and Otolaryngology, the St. Joseph County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Jefferson Medical College, Philadelphia, in 1891.

David S. Linvill, M.D., of Columbia City, died December 10, aged sixty-five years. Dr. Linvill was a member of the Indiana State Medical Association and a fellow of the American Medical Association. He graduated from the Detroit College of Medicine and Surgery in 1886.

William W. Neff, M.D., of Green's Fork, died December 19, aged seventy-two years. Dr. Neff had been ill for many weeks.

William Reed Boggs, M.D., R.F.D., Indianapolis, died December 21, aged seventy-three years. Dr. Boggs was a member of the Indiana State Medical Association and a fellow of the American Medical Association. He graduated from the Kentucky School of Medicine, Louisville, in 1883.

William F. Smith, M.D., of Huntington, died December 29, aged sixty-four years. Dr. Smith was a member of the Huntington County Medical Society, the Indiana State Medical Association and the American Medical Association. He graduated from the Curtis Physio-Medical Institute, Marion, Indiana, in 1896.

Calvin W. Burket, M.D., of Warsaw, died December 28, aged eighty-six years. Dr. Burket had not been in active practice for several years. He graduated from the Medical College of Ohio, Cincinnati, in 1866.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in The Journal of The Indiana State Medical Association. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

Dr. J. W. H. Smith, of Detroit, Michigan, has taken a position on the active staff of Dr. Scherer's Clinic at Martinsville.

Dr. and Mrs. F. G. Jackson and daughter, of Muncie, will sail January 25th for an extensive Mediterranean cruise and European tour.

Dr. A. E. Rhein, of Terre Haute, has returned after spending fourteen months in Vienna and Berlin, where he took postgraduate eye, ear, nose and throat work.

The regular monthly Seminar of the Indiana University School of Medicine was held in the Medical School Building, Monday, December 19th. Hospital cases were presented.

The Abbott Laboratories have published a booklet on the subject of ampule medication which may be obtained from that company without cost upon request by the physician.

The Northeastern Indiana Academy of Medicine held its meeting at the Gawthrop Hotel, Kendallville, December 22. Papers were presented by Dr. J. C. Fleming, of Elkhart, and Dr. Charles G. Beall, of Fort Wayne.

THE Clark County Medical Society held a meeting at Jeffersonville, December 13th, at which time the following officers were elected for 1928: President, Ralph W. Bruner; vice-president, Giles E. Mowrer; secretary, Samuel L. Adair.

THE following officers have been elected by the Jackson County Medical Society for the coming year: President Dr. H. P. Graessle, Seymour; secretary-treasurer, Dr. G. H. Kamman, Seymour; delegate to state convention, Dr. H. P. Graessle.

DR. CARL S. OAKMAN, of Muncie, spent the month of November visiting many x-ray and radium clinics in Philadelphia, New York and Boston, and also visiting the convention of the Radiological Society of North America held at New Orleans.

AT the annual reorganization meeting of the Madison County Medical Society held recently the following officers were elected: President, Dr. D. S. Quickel; vice-president, Dr. S. J. Stottlemeyer; secretary-treasurer, Dr. M. A. Austin (re-elected.)

ALL of the departments of the State Board of Health are now in the State House Annex Building at the corner of Market Street and Senate Avenue, Indianapolis. This is the old Medical Building which has been reconstructed for additional office space for the State of Indiana.

THE Floyd County Medical Society elected the following officers to serve for the year 1928 at its annual meeting held December 9, 1927: President, William H. Garner; vice-president, Anna McKamey; secretary-treasurer, P. H. Schoen; censors, C. C. Funk, J. Y. McCullough and Walter A. Hall.

AT the meeting of the Wells County Medical Society held December 20, 1927, the following officers were elected for 1928: President, Dr. Louis Severin, Bluffton; vice-president, Dr. O. G. Hamilton, Bluffton; secretary-treasurer, Dr. Max M. Gitlin, Bluffton; delegate to State Association, Dr. D. C. Wybourn, Ossian.

THE Wabash County Medical Society recently elected the following officers for 1928: President, J. W. G. Stewart, Wabash; vice-president, James Wilson, Wabash; secretary-treasurer, O. G. Brubaker, North Manchester. Beginning with January, 1928, meetings of this society will be held the first Thursday evening of each month.

FOR the third year in succession the Rush County Medical Society leads the membership race. On December 23, Dr. C. C. Atkins of Rushville, secretary of Rush County Medical Society, sent in the 1928 dues for the twenty-one physicians in Rush County, eligible to membership in their county medical society. This is a real record from a real county medical society.

THE United States Civil Service Commission announces open competitive examinations for Assistant Medical Officer, Associate Medical Officer and Senior Medical Officer. Applications for these positions will be rated as received by the Civil Service Commission at Washington until June 29, 1928. Full information may be obtained from the U. S. Civil Service Commission at Washington, D. C.

THE Fountain-Warren County Medical Society held a meeting in Attica, December 1, at the home of Dr. Roy Burlington. Dr. Louis G. Segar, of Indianapolis, presented a paper on "Infant Feeding." The following officers were elected for the year 1928: President, Dr. H. D. Kendall, of Newtown; vice-president, Dr. Richard Stephenson, of West Lebanon; secretary, Dr. A. L. Spinning, of Covington.

THE Kosciusko County Medical Society held its annual meeting at Warsaw, December 20, 1927. Dr. Albert E. Bulson, Jr., of Fort Wayne, presented a talk on "Medical Ethics." Officers for the society for the year 1928 were elected as follows: President, M. G. Yocum, Mentone; vice-president, F. H. Kelly, Argos; secretary and treasurer, C. C. DuBois, Warsaw; delegate to the State Association meeting, W. B. Siders. Warsaw.

THE United States Civil Service Commission announces open competitive examination for Dietitian. Applications will be rated as received by the Civil Service Commission at Washington, D. C., until June 29, 1928. Competitors will not be required to report for examination at any place but will be rated on their education, training and experience. Full information may be obtained from the United States Civil Service Commission at Washington, D. C.

THE United States Civil Service Commission announces open competitive examinations for graduate nurse (visiting duty) and graduate nurse (junior grade). Examinations are to fill vacancies in the departmental service, Washington, D. C., in the Veterans' Bureau and in the Indian and Public Health Service. Applications will be rated as received until June 30, 1928. Full information may be obtained from the U. S. Civil Service Commission at Washington, D. C.

A program of music and reading was given by the children of members of the Woman's Auxiliary of the Indianapolis Medical Society recently. Mrs. Charles F. Voyles, Mrs. William S. Tomlin, and Mrs. Homer C. Hamer were in charge of the program. Children participating in the program were Charles P. Emerson, Jr., Phoebe Emerson, Ross Rissler, Rose Dowd, Maietta Coble, Mary Margaret Ruddell, Mary Gertrude Cregor, Margaret Dowd, Anna Louise Conley, John M. Cregor, John and Robert Courtney and Alfred Dowd.

STATE recognition of the high rank of Saint Luke's International Hospital School for Nurses, Tsukiji, Tokyo, was officially confirmed by the Imperial Japanese Department of Education recently. The official decree confers college (semmon gakko) rank on the institution, the course of study being for three years, with one year extra for those taking special higher training. The school is the first institution for nurses in Japan to be thus recognized, no girls being admitted without a diploma from a girls' high school. Saint Luke's International Hospital is under the management of the American Episcopal Mission.

EXAMINATIONS for the American Board of Otolaryngology were held in Detroit, September 12th, during the session of the American Academy of Ophthalmology and Otolaryngology. One hundred and two applicants appeared for examination, with .107 per cent failures. Examination was held in Memphis on November 14th, preceding the session of the Southern Medical Association, with .127 per cent failures. In the course of the past year, three hundred sixty-nine applicants have been examined. In 1928 examinations will be held in Minneapolis, on June 11th, at the session of the American Medical Association, and in St. Louis, on October 15th, during the meeting of the American Academy of Ophthalmology and Otolaryngology. Prospective applicants for certificates should address the secretary, Dr. W. P. Wherry, 1500 Medical Arts building, Omaha, Nebraska, for proper application blanks.

DR. J. C. BURKLE, of Lafayette, chairman of the state organization of county secretaries, has selected the following county secretaries to serve on the executive committe: Dr. Paul W. Ferry, Kokomo; Dr. E. M. Shanklin, Hammond; Dr. A. M. Mitchell, Terre Haute; Dr. L. R. Pearson, Indianapolis; Dr. Harry P. Ross, Richmond. This committee has the future of the organizations in hand and invites suggestions from members of the State Association as to how they think the interests of the Association can best be served. How can the county secretaries be induced to work a little harder to have a hundred per cent membership and program? Do you think prizes should be offered for the best work? Are the programs in your county what you think they should be? Articles will be found in THE JOURNAL from time to time which may help secretaries in their work. If you have any suggestions please write to Dr. Burkle or any member of the committee given above.

IN this issue appears a two-page colored insert of Lister Brothers, Inc., of New York City. For the convenience of readers, a partial list of their distributors in the field covered by this journal is herewith given: Reed Drug Company, Anderson; Wiles Drug Company, Bloomington; B. D. Houseworth, Elkhart; Kute and Conner, druggists, and Perrin the Druggist, Elwood; H. A. Woods Drug Company, and Charles Lech and Company, Evansville; Wayne Heights Pharmacy, Fort Wayne; Summers Pharmacy and Weis Drug and Stationery Store, Hammond; the Hogan Drug Company, the Schnaible Drug Company, the Goodnight Pharmacy, the Wells-Yeager-Best Company, Lafayette; Brown's Pharmacy, Lagrange; Lion Drug Store, Laporte; W. H. Porter and Company, Logansport; Meyer Brothers Company, Muncie; Newcastle Elevator Company, Newcastle; the A. G. Luken Drug Company, Richmond; Morrison-DePrez Company, Shelbyville; Brodbeck Brothers, South Bend; Bert Raines, Terre Haute; H. C. Hueber, Druggist, Union City; C. S. Miller Drug Store, Vincennes; Bradley Brothers, Wabash.

I. E. CARLISLE, M.D., of Sedalia, the new secretary of the Clinton County Medical Society, certainly is on the job. The Program Committee of that county medical society, which is known as one of the best in the state, already has formulated the following program for 1928: *January fifth*—Pneumonia, Medical, Dr. N. W. Clark; Surgical Sequella, Dr. M. F. Boulden; Round Table Discussion led by Drs. J. E. Robinson and S. B. Sims; *February second*—Medical aspects, Dr. L. L. Harding; X-ray findings, Dr. A. G. Chittick; Surgical, Dr. H. H. Royster; Round table discussion led by Dr. W. C. Mount. *March first*—Borderline Neurology, Dr. I. E. Carlyle; Round table discussion led by Dr. M. F. Boulden. *April fifth*—Ladies' night. Speaker to be supplied. *May third*—Medical Economics, Thomas A. Hendricks; Round table discussion; General. *June seventh* — Obstetrics and Gynecology; speaker to be supplied. *September sixth*—Eye Strain, Dr. C. A. Robinson; Round table discussion led by Dr. J. R. Sickler. *October fourth*—Report of State meeting, Dr. L. L. Harding. General discussion. *November first*—Pediatrics. Speaker to be supplied. *December sixth*—Election of officers.

AT a special meeting of the State Board of Health, November 30th, a conference was had with mayors, city engineers and other official representatives of the municipalities located within the drainage area of Lake Michigan. Following this conference the State Board of Health issued an official order to the following cities and towns requiring that immediate steps be taken to eliminate pollution of Lake Michigan and its tributary streams within the State of Indiana by domestic sewage and industrial waste. This order applies to the cities of Whiting, Hammond, East Chicago, Gary, Hobart and Michigan City and to the incorporated towns of Munster and Highland.

The State Board of Health is now making a sanitary survey of the St. Mary's River from the Ohio State line to Fort Wayne and plans have been completed for a sanitary survey of the St. Joseph River through the cities of Elkhart, Mishawaka and South Bend. A sanitary survey of White River from Spencer to Muncie has recently been completed. Every city of Indiana is facing the problem of sanitary treatment and disposal of its sewage waste because the public is demanding protection of public water supplies through elimination of stream and lake pollution.



NEW QUARTERS OF THE INDIANA STATE BOARD OF HEALTH

ALL departments of the State Board of Health are now in the State House Annex Building at the corner of Market Street and Senate avenue, just across Senate avenue from the State House. On the first floor of the Annex Building are the Executive Offices, Housing, School Hygiene, Communicable Diseases, Child Hygiene, Epidemiology, Venereal Diseases, Public Health Nursing and Vital Statistics. On the second floor are the Food and Drugs, Water and Sewage, Food, Milk and Water Laboratories, Bacteriological and Pasteur Laboratories, Weights and Measures and Oil Inspection. The new quarters are well arranged and convenient for the activities of the department. The State House Annex is the old medical building which has been reconstructed for additional office space for the state of Indiana. The building is one hundred twenty-five feet long and sixty-five feet wide; has five stories and basement; contains seventy-one rooms of which fifty are offices and twenty-one for storage. The State Board of Health will occupy the first and second floors and the basement. All mail and express for the State Health Department in any of its divisions should be addressed to the State House Annex.

In addition to the articles already enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the A. M. A.; Abbott Laboratories:

Staphylococcus Mixed Bacterin.
Typhoid Prophylactic, 5 cc. vials.
Typhoid Prophylactic, 20 cc. vials.

Cutter Laboratory:

Pollen Extracts-Cutter, 5 cc. vial.
Alkali Weed Pollen Extract Concentrated-Cutter; Allscale Pollen Extract Concentrated-Cutter; Annual Saltbrush Pollen Extract Concentrated-Cutter; Arizona Ash Pollen Extract

Concentrated-Cutter; Bermuda Grass Pollen Extract Concentrated-Cutter; Black Walnut Pollen Extract Concentrated-Cutter; Box Elder Pollen Extract Concentrated-Cutter; Burning Bush Pollen Extract Concentrated-Cutter; Canary Grass Pollen Extract Concentrated-Cutter; Careless Weed Pollen Extract Concentrated-Cutter; Coast Sagebrush Pollen Extract Concentrated-Cutter; Cocklebur Pollen Extract Concentrated-Cutter; Common Ragweed Pollen Extract Concentrated-Cutter; Corn Pollen Extract Concentrated-Cutter; Cottonwood Pollen Extract Concentrated-Cutter; False Ragweed Pollen Extract Concentrated-Cutter; Foxtail Grass Pollen Extract Concentrated-Cutter; Giant Ragweed Pollen Extract Concentrated-Cutter; Johnson Grass Pollen Extract Concentrated-Cutter; June Grass Pollen Extract Concentrated-Cutter; Lamb's Quarters Pollen Extract Concentrated-Cutter; Marsh Elder Pollen Extract Concentrated-Cutter; Mountain Cedar Pollen Extract Concentrated-Cutter; Mugwort Pollen Extract Concentrated-Cutter; Oak Pollen Extract Concentrated-Cutter; Olive Pollen Extract Concentrated-Cutter; Orchard Grass Pollen Extract Concentrated-Cutter; Plantain Pollen Extract Concentrated-Cutter; Red Root Pigweed Pollen Extract Concentrated-Cutter; Red Top Pollen Extract Concentrated-Cutter; Russian Thistle Pollen Extract Concentrated-Cutter; Rye Grass Pollen Extract Concentrated-Cutter; Sagebrush Pollen Extract Concentrated-Cutter; Shad Scale Pollen Extract Concentrated-Cutter; Timothy Pollen Extract Concentrated-Cutter; Tumbleweed Pollen Extract Concentrated-Cutter; Velvet Grass Pollen Extract Concentrated-Cutter; Western Ragweed Pollen Extract Concentrated-Cutter; Western Waterhemp Pollen Extract Concentrated-Cutter; Wild Oat Pollen Extract Concentrated-Cutter; Yellow Dock Pollen Extract Concentrated-Cutter.

Lederle Antitoxin Laboratories:
Anaerobic Antitoxin (Polyvalent)-Lederle.

Merck & Co., Inc.:
Erythrol Tetranitrate Tablets-Merck, ¼ grain.

H. K. Mulford Co.
Ampuls Dextrose (d-Glucose) 10 Gm., 20 cc.
Ampuls Dextrose (d-Glucose) 25 Gm., 50 cc.

Parke, Davis & Co.:
Ephedrine Sulphate—P. D. & Co.

Prophylacto Mfg. Co.:
Ephedrine Hydrochloride—Pemco.

E. R. Squibb & Sons:
Insulin Squibb, 100 units, 10 cc.

Tailby-Nason Co.:
Nason's Palatable Cod Liver Oil.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

November 14, 1927.

Meeting called to order at 4 P. M.

Present: William N. Wishard, M. D., Chairman; J. A. MacDonald, M D., by proxy and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held November 7, read and approved. The release, "The Discovery of Germs" read and approved for publication Monday, November 21.

The following bills were approved for payment:

W. K. Stewart Co. $.90
Central Press Clipping Service 7.74

The following letter was received from the Fugate Remedy Company in answer to a letter written by the Bureau asking this company not to make any statements that might lead the public to believe that the State Medical Association sponsored products of this company:

"We are in receipt of your letter of recent date, relative to the quotation used in our recent advertising.

"It was not our intention to give the impression that the booklet we published was in any way sponsored by the Indiana State Medical Association, nor that any approval of the booklet had been given.

"In keeping with our high regard for the Indiana State Medical Association, and desiring at all times to merit their kindest wishes, we have discontinued the use of the quotation to which you referred."

The following letter was received from the Medical Review of Reviews, a periodical published in New York City:

"We beg to call your attention to a matter that has excited some comment among the members of the medical profession, namely the attempt on the part of the manufacturer of a certain brand of cigarettes to give the public the impression that the physicians of this country endorse any one cigarette preferentially on a basis of healthful properties.

"We believe, as do a great number of leading physicians throughout the country with whom we have communicated, that this practice is pernicious and undermines the public's faith in the disinterestedness and honesty of the medical profession. In pursuance of this idea, we have communicated with a large number of physicians and have asked them the following two questions. The first was "Do you not agree with us that it is impossible for one cigarette to have any advantage over all others in regard to throat ease or irritation?" to which the answer was almost unanimously "yes." The second was, "Is it not your observation that there is no scientific reason for preference for any given cigarette and that any preference is on a taste basis?" to which the answer was almost unanimously "yes."

"On the other hand, the advertisements which you may have noticed throughout the country claim that the endorsements which this company has received for this particular cigarette represent the authentic voice of the 140,000 physicians of this country.

"We ask therefore, that in your capacity of leading officer of your state medical society you ask the physicians of your state to pass a resolution against this type of advertising. We ask that this resolution be so worded that it will endeavor to put to an end the practice of manufacturers securing medical endorsements and making them, by implication, wholly authoritative.

"We are enclosing a copy of the symposium so that you may see in greater detail the situation in which you undoubtedly have a keen interest."

The Bureau noted the following statement which appeared in the Journal of the Michigan State Medical Society, edited by Dr. F. C. Warnshuis, who was a guest

at the annual meeting of the State Medical Association in September:

"It was our privilege to attend the Annual Meeting of the Indiana State Medical Association in Indianapolis on September 28. We were impressed by the alert and manifest interest of its House of Delegates and the exemplary activity during the year of the permanent committees. Indiana's profession is accomplishing a real task in its campaign of newspaper publicity that is educating the public in regard to scientific medicine. The concerted influence of the profession also secured the passage of a new medical law last winter that bids well to limit cult activity and tresspass into the fields of medicine by under-educated physicians. We have always obtained inspiration and guidance from the methods utilized by the Indiana Medical Association and are appreciative of having had the opportunity of meeting these medical leaders."

There being no further business the meeting was adjourned. The foregoing minutes were approved in each separate part and as a whole November 21, 1927.

WM. N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

November 28, 1927.

Meeting called to order at 5 P. M.

Present: William N. Wishard, M.D., Chairman; J. A. MacDonald, M.D., Murray M. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held November 14 read and approved.

The release "Nature Curing or Physical Therapy" read, corrected and approved for publication December 5.

The statement of expense of the Publicity Bureau follows: January 1 to December 1, 1927.

Mimeograph paper, plain yellow and white	$ 55.20
Envelopes	44.21
Clippings	62.81
Stencils and mimeograph supplies	32.12
Repairs on mimeograph	8.50
Printing on door	3.00
Miscellaneous office supplies	3.51
Postage	124.00
Total	$333.35
Amount allowed by budget committee	$ 1500.00
Amount spent to date	333.35
Balance	$ 1166.65

This statement is prepared for the Budget Committee. Due to the fact that the Publicity Bureau anticipates an increased field of activity for 1928, the Bureau will ask the Budget Committee for an appropriation of $750.00 for 1928.

A request was received from "Babyhood" a magazine devoted to the interests of infants and child care" to be placed upon the mailing list to receive our weekly release.

Advertisements entitled "Little Chats About Health" appearing in an Indianapolis paper over the signature of an Indianapolis pharmacy came to the notice of the Bureau. The Bureau thinks that these articles already presented in the press are excellent. The importance of consulting one's family physician is constantly stressed in these advertisements. The secretary was authorized to write a letter to this pharmacy stating that these articles had come to the attention of the Bureau and that those already presented in the press seem excellent. The following well illustrates the type of advertisement of the pharmacy mentioned:

"A physician compares people and their food with an automobile motor and its fuel. In hot weather each requires less than in cold as any excess produces heat which above a certain point is very undesirable.

"Not only will eating less food help to keep you cool, but it will prevent the troubles which associate with excessive waste matter in the body.

"The subject of a proper diet is a very important one to which your physician has given much attention.

"Always consult him about any matter in connection with your health."

The executive secretary was authorized by the Bureau to act as a judge in the "Keep Fit" contest which is sponsored by the Indianapolis News.

Report received from meeting of the Tri-County Medical Society at North Vernon on October 26.

The Bureau authorized the chairman and secretary to draw up a letter approving the stand of the Medical Review of Reviews against physicians endorsing "any one cigarette preferably on a basis of healthful properties."

There being no further business the meeting was adjourned.

The foregoing minutes were approved in each separate part and as a whole December 5, 1927.

WM. N. WISHARD,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

December 5, 1927.

Meeting called to order at 4:45 P. M.

Present: William N. Wishard, M.D., Chairman; J. A. MacDonald, M.D., by proxy, and Thomas A. Hendricks, Executive Secretary.

The minutes of the meeting held November 28 read, corrected and approved.

The following bills were approved for payment:

Central Press Clipping Service	$ 5.00
The Whitaker Press, 4 page folder	23.50
Wm. P. Walker, stencils, ink and repairing mimeograph	14.25
Total	$42.75

The following letter was received from Mrs. Edna Hatfield Edmondson, executive secretary, Indiana Parent-Teacher Association:

Indiana University Extension Division,
Bloomington, Ind.
December 2, 1927.

Mr. Thomas A. Hendricks,
Executive Secretary,
Indiana State Medical Association,
Hume-Mansur Building,
Indianapolis, Indiana.

My Dear Mr. Hendricks:

The mailing list of the Parent-Teacher Bulletin has now increased to about 700 names. I wonder if it would be possible for you to increase the number of medical association releases to cover this entire list. I would like also to have enough of these to give a half dozen or so to the University Package Library Service. You have been so generous in this matter that I hesitate to ask for this added number, but I believe that these releases will reach people in a very worth while way. I know that they have attracted attention, even outside of the state. Thanking you, I am

Very sincerely,
Edna Hatfield Edmondson, Ex. Secy.,
Indiana Parent-Teacher Association.

The secretary was instructed to supply Mrs. Edmondson with the necessary additional copies of each release of the Bureau.

Letter received from the Editor of the Journal suggesting that the Publicity Bureau should keep the question of periodic health examination before the public and the profession.

Reports received from the Tri-County meeting at North Vernon, October 26, and the meeting of the Morristown Civic Club, November 15.

Reports of alleged overcharge for use of radium by Dr. T. O. Gasaway received by the Bureau of Publicity and referred to the Better Business Bureau. Copies of report sent to the editor of the Journal of the Indiana State Medical Association.

The following letter was addressed to the Budget Committee in regard to expenses for 1928.

December 3, 1927.

Mr. Thomas A. Hendricks, Secretary,
Indiana State Medical Association,
804 Hume-Mansur Bldg.,
Indianapolis, Ind.

My Dear Mr. Secretary:

I am in receipt of your letter of December 1st asking me to indicate the amount of our probable expenses of the Bureau of Publicity for the year 1928.

Our estimate last year was based on the probability of extending our work very considerably. Owing to the meeting of the State Medical Society in Indianapolis and the necessary attention given it by your office this year, our plan has been somewhat interferred with and we have only incurred ordinary traveling expenses and a few incidentals, totaling $339.49.

We should undertake the extension of our work during 1928 and press it vigorously. It seems generally conceded that the work thus far has proven most successful and helpful and has carried a real educational value.

For the furtherance of our work for the year 1928 I suggest the amount of $750.00.

As heretofore the Bureau will be most careful in incurring and paying any bills and if there should be any surplus it will be shown on our report at the end of the year.

Your report of a balance from last year's allowance does not include the expenses for the month of December which should be added to those for the first eleven months of the year.

Sincerely yours,
Wm. N. Wishard, Chairman,
Bureau of Publicity,

The weekly release "Cigarette Advertisements" was prepared for publication in the papers Monday, December 12.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole December 12, 1927.

WM. N. WISHARD,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

December 12, 1927.

The meeting was called to order at 4:45 P.M.

Present: Wm. N. Wishard, M.D., Chairman; J. A. MacDonald, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held December 5 read, corrected and approved.

The release, "The Conquest of Disease" read, corrected and approved for publication December 19.

A copy of "The Physical Examinist" received and one member of the Bureau was commissioned to review this magazine and make a report upon it at the next meeting.

Report received of the meeting of the Decatur County Medical Society at Greensburg, Indiana, November 18.

Request received for speaker to make the principal talk at the annual meeting of the Knox County Medical Society, December 13. A pediatrician preferred. Secretary reported and speaking date has been filled.

Pamphlet received from the Medical Society of the State of New York opposing the endorsement of commercial products by physicians. Referring to the recent endorsement by individual physicians of a certain brand of cigarettes, this pamphlet says in part:

"When, however, non-therapeutic agents, such as, for example, cigarettes, are advertised as having the recommendation of the medical profession, the public is thereby led to believe that some real scientific inquiry has been instituted, and that the endorsement is the result of painstaking and accurate inquiry as to the merits of the product.

"What probably happened, we presume, is that the company sent to the doctors in question a carton or more of the cigarettes and then later wrote them asking their opinion of them, to which in all good faith the doctors, no doubt, responded as is represented. We have no knowledge that this was the course pursued but from our general knowledge as to the way in which advertising campaigns of this kind are conducted, think this is probably a plausible explanation.

"By this advertisement, however, the general public is given the impression that there has been a real scientific inquiry as to the therapeutic effect of the cigarettes in question, and that a real scientific investigation has been made, as a result of which the conclusion has been scientifically arrived at that the cigarettes in question were 'less irritating to sensitive or tender throats than any other cigarettes.' "

The Bureau reviewed items sent to the American Medical Association for the Indiana column.

The Bureau authorized a three-year subscription to Hygeia starting February, 1928, when the old subscription runs out. This was authorized as three-year subscription could be gotten for $6.00 as against $9.00 the price of three successive one-year subscriptions.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole December 19, 1927.

WM. N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

December 19, 1927.

The meeting was called to order at 4:45 P.M.

Present: Wm. N. Wishard, M.D., Chairman; Murray N. Hadley, M.D.; and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held December 5 read, corrected and approved.

The release, "Holiday Health" read and approved for publication December 24.

The following reports of meetings were received: Eleventh district medical meeting, October 20, subject, "Goitre." The Knox County Medical Society meeting, Vincennes, December 13, subject "Progress in Pediatrics."

The attention of the Bureau was brought to a statement made by the councilor of the fifth district at the mid-winter council meeting held December 16 at Indianapolis. He says that a public health meeting was held under the auspices of the Y. M. C. A. at Richmond, Indiana, at which a Richmond physician gave out circulars advertising the Koch Cancer cure. According to the report of the district councilor the statement was made at the Wayne-Union County Society meeting on Thursday, December 15, that the Bureau of Publicity had given its authorization for this meeting. The Bureau did not authorize this meeting and knows nothing whatever about the physician who distributed the Koch Cancer Cure propaganda aside from the fact that this man is not in good standing in the county or state association. The secretary was instructed to write the secretary

of the Wayne-Union Medical Society telling of the councilor's report and of the fact that this office did not know anything about this meeting and had nothing whatever to do with it.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole, Dcember 27, 1927.

WM. N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

LAWRENCE COUNTY MEDICAL SOCIETY

The Lawrence County Medical Society held its meeting at Bedford, December 7th.

Dr. John T. Freeland presented a paper on "Salpingitis" which was very interesting and generally discussed. There also was an interesting discussion in regard to smallpox.

The following officers were elected for 1928: President, Dr. Norman E. Byers, Bedford; vice-president, Dr. John A. Gibbons, Mitchell; secretary-treasurer, Dr. W. H. McKnight, Bedford; delegate to State Association meeting, Dr. Harry Ragsdale, Bedford.

The Lawrence County Medical Society will hold its meetings the first Wednesday of each month at the New Bedford Hotel. It is a live society and those who fail to attend its meetings do not realize what they are missing.

W. H. MCKNIGHT, M.D.,
Secretary.

FLOYD COUNTY MEDICAL SOCIETY

December 9, 1927.

The Floyd County Medical Society met in annual meeting at the Tavern Hotel, New Albany, on the above date, with a fair attendance.

This meeting was different from previous annual meetings. In addition to the regular routine of business, annual report, election of officers and banquet, we had an after dinner speaker. Not a medical man, but a minister, Rev. J. G. Sibson, pastor of Wesley Chapel M. E. Church. Rev. Sibson is not only an interesting talker, but witty and entertaining as well. His talk was appreciated and enjoyed by all.

After a brief business session, the following officers for the year 1928 were elected:

President, W. H. Garner, M.D., of New Albany; vice-president, Anna McKamey, M.D., of New Albany; secretary-treasurer, P. H. Schoen, M.D., of New Albany; C. C. Funk, M.D., of New Albany; censors, J. Y. McCullough, M.D., of New Albany; W. A. Hall, M.D., of New Albany.

Delegates to the state meeting will be named later.

Following the election of officers, a social session was held in which good fellowship and fraternal spirit reigned supreme.

P. H. SCHOEN, M.D.,
Secretary.

TIPPECANOE COUNTY MEDICAL SOCIETY

December 9, 1927.

The regular monthly meeting of the Tippecanoe County Medical Society was held at the Home Economics Building at Purdue University, December 8th, 1927. Dinner was served at 6:15 P. M. and the meeting was held in the auditorium.

The following officers were elected for 1928: President, Dr. H. J. Laws; vice-president, Dr. R. D. Bayley; secretary, Dr. J. C. Burkle; treasurer, Dr. Charles Hupe; censor for three years to succeed Dr. M. M. Lairy, Dr. Earl Van Reed.

The application of Dr. John S. Ketcham for membership by transfer from Clinton County Medical Society was accepted unanimously.

Our meeting was a joint meeting with the Druggists and Dentists, known as the three D's.

The first paper was "Basal Metabolism in Diagnosis" presented by Professor C. J. Klemme of Purdue. Difficulties encountered in this work were pointed out, also the uncertainty in readings at times. Variations are sure to be encountered. Basal metabolism is confirmatory but not absolute. Discussion was led by Dr. R. D. Bayley.

The second paper was "Ethical Pharmacy" presented by Professor C. O. Lee of Purdue. Special emphasis was placed on the great need of druggists and doctors following their respective code of ethics closely, having a thorough understanding with each other. In the discussion many important points were brought out whereby co-operation can be had, the great need of the first consideration being the patient and customer. Relations between doctors and druggists in Lafayette perhaps come much nearer the ideal than in most other cities of the state. Everyone left feeling that much valuable discussion had been brought out.

Professors Klemme and Lee were extended a rising vote of thanks for their splendid papers.

J. C. BURKLE, M.D.,
Secretary.

WOMAN'S AUXILIARY

Indianapolis, Indiana,
January 1, 1928

Editor THE JOURNAL:

At the opening of the New Year, I take pleasure in greeting all the ladies who are now members of the Woman's Auxiliary to the Indiana State Medical Association, and desire to say to potential members in this broad state of ours, "We need you!" Yes, we need every physician's wife to strengthen our own State Auxiliary which in turn strengthens the National Auxiliary, and helps it to take its rightful place, shoulder to shoulder, with the American Medical Association, as a united force of helpfulness and service.

Since our state organization in September there has been encouraging response from Anderson, Terre Haute, Crawfordsville, and from the Eleventh District in its meeting at Delphi. Indianapolis has the pioneer Woman's Auxiliary. There is much to be done, so, wives, prevail upon your husbands to support this movement! We must have their whole-hearted co-operation for the physician is the head of the Auxiliary household.

I am sorry to say that many physicians do not see the possibilities of the Auxiliary and hesitate to say to their wives, as my husband said to me, "Get interested in this Woman's Auxiliary movement! It is a fine thing! Just think what a great moral force a National Woman's Auxiliary will be!" I have been interested for four years, and take this opportunity to say to the eligible women in Indiana—"Get Interested." We can do nothing in hit or miss groups. We will count in such an organization as thousands of women are counting in other states. We can help our husbands in the good fellowship and friendships we develop; we can help them in our respective clubs; we are the logical connecting link between the profession and the laity. Have vision, ladies! Such affiliations will be to our future mutual pleasure, benefit and service.

MRS. F. W. CREGOR,
President Woman's Auxiliary of the Indiana State Medical Association.

THE COUNCIL

The regular mid-winter meeting of the Council of the Indiana State Medical Association convened at 10:15 a. m. Friday, December 16, at the Indianapolis Athletic Club, Indianapolis. Upon the call to order by Wm. R. Davidson, chairman, the roll call showed the following present: Frank W. Cregor, president 1927; George R

Daniels, president 1928; Charles E. Gillespie, president-elect; Wm. A. Doeppers, treasurer, A. E. Bulson, Jr., editor of THE JOURNAL.

MEMBERS OF THE COUNCIL

1st District—Wm. R. Davidson, Evansville.
2nd District—G. D. Scott, Sullivan.
3rd District—Walter J. Leach, New Albany.
4th District—H. P. Graessle, Seymour.
5th District—J. H. Weinstein, Terre Haute.
6th District—Edgar C. Denny, Milton.
7th District—E. E. Padgett, Indianapolis.
8th District—M. A. Austin, Anderson.
9th District—F. S. Crockett, Lafayette.
10th District—E. E. Evans, Gary.
11th District—Not represented.
12th District—Not represented.
13th District—H. M. Hall, New Carlisle.

THOMAS A. HENDRICKS,
Executive Secretary.

The reading of the minutes of the council meetings during the annual convention at Indianapolis last September was dispensed with, as these were printed in the October number of THE JOURNAL and approved.

DISTRICT REPORTS

Each councilor reported upon the work that is being done in his district. Dr. Cregor suggested that each councilor devote a few minutes of his report to an outline of the post-graduate work in these various district reviews. The outstanding points in each report follow:

FIRST DISTRICT—Dr. Davidson reports the first district in good shape. Warrick county is back in the running and "going good". Talk of a combination between Perry and Spencer counties. This would make a strong society with meeting centers at Cannelton, Rockport, and Tell City. Pike county not as strong as it should be, as the roads are bad and it is difficult to have meetings except in the late spring, summer and early fall.

General talk of consolidation of county societies often stimulates individual activity in the various county societies.

SECOND DISTRICT—Dr. Scott, the new councilor, receives a welcome and is formally introduced to the council. Dr. Scott says he will do everything possible to carry on the work that is expected of him. He reports a scarcity of doctors in Sullivan county due to the fact that few new doctors are coming in to replace the "old timers" who have discontinued practice or have died.

THIRD DISTRICT—Dr. Leach reports a good district meeting. He says all counties of his district are very well organized except Crawford.

FOURTH DISTRICT—Dr. Graessle reports the various county societies in the district in good shape. The slight loss in membership in the district is due mostly to removals. Did not know until recently that Brown County was a member of the fourth district. This is a dead county from a medical organization standpoint.

The councilor reports that the first idea of post-graduate study was started by the physicians residing in Seymour about three years ago. At the time there was no idea of connecting the work with the university. The first year, the course was given over to general medicine and diagnosis, the second year to surgery, and the third to the specialties. This, according to Dr. Graessle, has not been more than a county affair. Physicians of Scott and Jennings county have been invited to attend the post graduate courses at various times. Post-graduate work is a fine thing, Dr. Graessle believes, and Indiana University has been doing its share.

FIFTH DISTRICT—This district is in good shape according to the report of Dr. Weinstein. The post-graduate course has been working in Vigo county but has just about used up all the material offered by Indiana University. Dr. Weinstein says that post-graduate work has been a splendid thing for Vigo county and that the University never has failed to have a speaker for each meeting. He believes that post-graduate work keeps any society from getting too much in a rut. Local members get tired of preparing and are tired of hearing what other local men have to say. Outside men stimulate interest in county medical society meetings. Before the post-graduate course was started, the average attendance of meetings was fifteen or sixteen. Since the establishment of post-graduate courses, the attendance has risen to forty. This year it was decided to again use local members and a dry clinic is being held alternately at the hospitals. The post-graduate course stimulated attendance, and this year there is an average attendance of fifty. Dr. Weinstein is heartily in favor of all counties having post-graduate courses. He reports a very enthusiastic meeting and the formation of a woman's auxiliary in Vigo county. The first formal meeting of the auxiliary was to be held January 3. Dr. Weinstein said that the number of night medical meetings in his county are being cut down. Noon luncheons in place of night staff hospital meetings are becoming customary and popular, as the noon staff meeting is being better attended than the night staff meeting.

SIXTH DISTRICT—Everything going well in the district, says Dr. Denny. Most of the programs of the various county societies are supplied by outside talent. For this reason the county societies of this district have not been very enthusiastic for post-graduate work. Dr. Denny spoke of the fact that S. Edgar Bond, a physician at Richmond, is alleged to have used a public health meeting sponsored by the Y. M. C. A. to circulate Koch cancer cure propaganda.

SEVENTH DISTRICT—The district meeting at Danville was one of the best medical meetings ever held in this district, according to Dr. Padgett. Work in Morgan county is still going a bit slow. Many 1928 applications for membership in the Indianapolis Medical Society are pending from physicians who never before have belonged to their county or state medical society.

EIGHTH DISTRICT—Dr. Austin reports much activity in the various county societies of the district. County societies in good shape. A membership gain of nine has been made during the year.

NINTH DISTRICT—District in good shape, says Dr. Crockett. Although Benton County Society does not hold regular meetings and meets upon call it has a good organization. The Warren-Fountain county society is probably the livest one of the district. The district president, Dr. Wm. F. McBride, and Dr. Crockett, the councilor, visited every county society in the district and reported the meetings universally interesting and worth while. Post-graduate course of Fountain-Warren county a success. Tippecanoe county society has been working under a three-year program. Frequent meetings have been held with lawyers, druggists and dentists. These have brought in new interests and have been quite successful. The county society is fortunate in the fact that it can draw from the faculty of the Purdue Pharmacy school for speakers upon subjects allied to the medical profession. The presence of two Class A hospitals with their monthly staff meetings, with the county society, make three meetings each month. However, they are not competitive, since staff meetings consider only hospital material and problems and leave presentation of scientific essays, etc., for the county society.

TENTH DISTRICT—Dr. Evans made a vigorous protest against too many medical meetings. Multiplicity in meetings has a tendency to hurt attendance at the county medical society. A rule has been passed in Lake county that no man shall be eligible to the staff of a hospital unless he is eligible to his county medical society. A halt must be called upon too many medical organizations, Dr. Evans maintains. The 10th district held a fine program at East Chicago this year.

THIRTEENTH DISTRICT—In good shape generally, Dr. Hall states. Outside talent always seems to be the best attraction. In St. Joseph county a clinic is held each Saturday morning in the hospitals at which outstanding or unusual cases are shown. This has proved very successful.

Marshall county is not organized, but most of the physicians are affiliated with adjoining county societies. The county itself is hardly large enough to require an organization of its own. Dr. Hall also spoke of the bad results from over-organization and a multiplicity of meetings.

GENERAL DISCUSSION OF DISTRICT REPORTS

In the general discussion that followed the councilor reports Dr. Crockett of Lafayette, suggested a large map showing the various districts be prepared at headquarters office and be brought to each councilor meeting.

Dr. Weinstein, of Terre Haute, said that the number of night medical meetings in his county was being cut down. Noon luncheons in place of night staff hospital meetings was becoming customary.

A general discussion followed as to the success of joint meetings between doctors and dentists. Dr. Crockett said that many things of common interest, such as the x-ray of teeth, brought up conflicting viewpoints, discussion on which was both interesting and vigorous. He said that more dentists turned out for these meetings than doctors.

Dr. Davidson, of Evansville, spoke of the fact that meetings with men of other professions were very much worth while. "It is well to get the other fellow's slant," he said.

Dr. Bulson, editor of THE JOURNAL, spoke of the fact that there was not enough co-operation between the dentists and physicians. Too often teeth were extracted irrespective of the patient's general condition, with harmful results. Dr. Padgett spoke of the fact that the orgy of teeth pulling should be held up, while Dr. Hall said a dental survey was being conducted in co-operation with the Mayo clinic where new facts concerning teeth extraction were being developed.

In discussing the post-graduate work, Dr. Cregor, of Indianapolis, said one of the big questions before the state medical association was, "What shall we do to make post-graduate study available for the men remaining at home?"

ECHOES AND REFLECTIONS OF THE 1927 CONVENTION

The expense account of speakers was discussed. Following a discussion of the subject by Doctors Davidson, Padgett, Bulson and Cregor, the council went on record favoring a plan by which an understanding should be had between the visitor and the state medical association in regard to the expenses charged by speakers whom we invite to attend and address annual meetings. Dr. Doeppers said that this attitude of the council should be known to the Program Committee.

It was moved by Dr. Crockett, and carried, that the exact amount of money to be allowed for traveling expenses of visitors who address the annual meeting be left to the Budget Committee.

The council went on record unanimously in favor of the installation of an amplifier at the general meeting at the next annual session at Gary.

A financial report on the income from the Technical Exhibit and cost of the 1927 annual convention were made.

SUGGESTIONS AND PROPOSALS FOR 1928 CONVENTION AT GARY, LAKE COUNTY

Each councilor was supplied with a special report by Dr. E. M. Shanklin, chairman of the Lake County Committee on Arrangements. This report, which gives a preliminary survey of the convention arrangements for 1928, was read by Dr. Evans, of Gary, and received with enthusiasm by the council. Dr. Evans said that the Lake County Medical Society had voted overwhelmingly in favor of a general meeting in 1928 as opposed to a sectional or clinical meeting.

The council went on record recommending that the Scientific Program Committee make arrangements for a general scientific meeting at the Gary session. It was understood that this recommendation does not establish a precedent and only goes for the Gary meeting. Motion to make the Gary meeting a general meeting was made by Dr. Evans, and seconded by Dr. Padgett, and carried.

The council went on record in favor of a banquet on Thursday evening instead of a public health meeting.

The council also went on record in favor of a "non co-ed" smoker on Wednesday night.

The council also favored making the trip through the steel mills an excursion for men only, if this meets the approval of the local arrangements and entertainment committee. As the trip through the steel mills is being planned for Wednesday afternoon, Dr. Davidson made the suggestion that the council meet Wednesday afternoon directly after the trip, at 4 o'clock if possible, and the first meeting of the House of Delegates should follow at 5 o'clock.

On motion of Dr. Padgett, the council went on record in favor of having no scientific exhibit this year. This must not be confused with th commercial or technical exhibit which will be held as usual.

Dr. Shanklin reported that practically the whole convention can be held at the new Gary Hotel, Gary, Indiana. The general meetings, committee meetings and technical exhibit can all be held at this hotel.

MEMBERSHIP REPORT

December 31, 1927

County Society	Dec. 31, 1927	Dec. 31, 1926	Loss-Gain	De-linquent	New Members	Removal	De-ceased	Reinstatements
1st District								
Posey	11	12	−1	1				
Vanderburgh	96	91	5		4		2	1
Warrick	4	4					1	
Spencer	10	11	−1			1		
Perry	11	10	1					1
Gibson	23	22	1	1	2	1	1	1
Pike	7	7						
Total	162	157	5	2	6	2	4	3
2nd District								
Knox	32	34	−2	2				
Daviess-Martin	27	29	−2	2	1	1		
Sullivan	24	25	−1			1	1	
Greene	15	17	−2	3	1			
Owen	6	7	−1	1				
Monroe	24	18	6	1	4			3
Total	128	130	−2	9	6	2	1	3
3rd District								
Lawrence	25	21	4		2			2
Orange	18	21	−3	2	1	2	1	
Crawford	4	6	−2	2				
Washington	9	10	−1	2	1			
Scott	3	3						
Clark	18	16	2	1	2	1		2
Floyd	30	34	−4	1		2	1	
Harrison	8		8		8			
Dubois	15	15				1		1
Total	130	126	4	8	14	6	2	5
4th District								
Brown								
Bartholomew	23	28	−5	1		4		
Decatur	20	20	0	1	1			
Jackson	18	18						
Jennings	10	11	−1			1		
Ripley	11	16	−5	2		3		
Jefferson	19	19	0					
Switzerland	6	6	0					
Dearborn-Ohio	20	19	1				1	1
Total	127	137	−10	4	1	8	1	1
5th District								
Parke-Vermillion	16	19	−3	3	1	1	1	
Putnam	16	16						
Vigo	113	117	−4	3	3	1	3	
Clay	19	16	3		2		1	1
Total	164	168	−4	6	6	2	5	1

6th District								
Hancock	15	15						
Henry	27	27		1	1			
Wayne–								
Union	52	52		1	3		2	
Fayette	14	14						
Rush	22	23	−1			1	1	
Shelby	22	26	−4	3	1	2	1	1
Franklin	6	5	1					1
Total	158	162	−4	5	5	3	4	2
7th District								
Hendricks	16	19	−3	1			2	
Marion	439	436	3	13	18	13	6	6
Morgan	21	21		1	1			
Johnson	10	10						
Total	486	486	0	15	19	13	8	6
8th District								
Madison	62	57	5	2	7	2		2
Delaware-Blackf'd	71	71		4	7	2	4	2
Jay	19	15	4		1			3
Randolph	24	22	2	1	3			
Total	176	165	11	7	18	4	4	7
9th District								
Benton	12	11	1		1			
Fountain-Warren	21	20	1		1			
Tippecanoe	69	63	6	2	9	1	1	
Montgomery	29	31	−2	1		1		
Clinton	26	26		1	1			
Tipton	12	13	−1	1				
Boone	12	14	−2	2	1	1		
Hamilton	21	22	−1	2	1			
Total	202	200	2	9	14	3	1	
10th District								
Lake	162	157	5	10	18	2		
Porter	22	24	−2	2				
Jasper-Newton	18	21	−3	3				
White	10	11	−1	1				
Total	212	213	−1	16	18	2		
11th District								
Carroll	18	15	3		1			2
Cass	36	40	−4	3		1		
Miami	22	24	−2	1		1		
Wabash	28	28		2	2			
Huntington	24	24		1	1			
Howard	39	36	3		2			1
Grant	42	41	1	2	3			
Total	209	208	1	9	9	2		3
12th District								
LaGrange	10	11	−1			1		
Steuben	14	14						
Noble	23	24	−1	1			1	
DeKalb	21	20	1		1			
Whitley	11	12	−1	1				
Allen	131	130	1	1	7	2	3	1
Wells	17	16	1		1		1	
Adams	20	19	1		1			
Total	247	246	1	3	10	3	5	1
13th District								
LaPorte	45	44	1		3	2		
St. Joseph	131	125	6	1	7	1		1
Elkhart	67	65	2	1	2		1	1
Starke								
Pulaski	6	7	−1	1				
Fulton	19	20	−1	1				
Marshall								
Kosciusko	23	24	−1		1	2		
Total	291	285	6	4	13	5	1	2

SUMMARY BY DISTRICTS

1st District	162	157	5	2	6	2	4	3
2nd District	128	130	−2	9	6	2	1	3
3rd District	130	126	4	8	14	6	2	5
4th District	127	137	−10	4	1	8	1	1
5th District	164	168	−4	6	6	2	5	1
6th District	158	162	−4	5	5	3	4	2
7th District	486	486	0	15	19	13	8	6
8th District	176	165	11	7	18	4	4	5
9th District	202	200	2	9	14	3	1	
10th District	212	213	−1	16	18	2		
11th District	209	208	1	9	9	2		3
12th District	247	246	1	3	10	3	5	1
13th District	291	285	6	4	13	5	1	2
Total	2692	2683	9	97	136	55	36	32

POLITICAL AND LEGISLATIVE PROBLEMS

National Problems.. A letter was read from Dr. Wm. C. Woodward, executive secretary of the Bureau of Legal Medicine and Legislation at the American Medical Association. This letter told of the proposed activities of the New England Anti-vivisection Society to introduce into the House of Representatives at Washington a bill for the exemption of dogs from vivisection. In order to prevent the enactment of any legislation that will hinder scientific research in the District of Columbia and other places under federal control, each councilor was asked to get in touch with each of the county societies in his district concerning this proposed legislation. Each county society was to write its congressman expressing opposition to any law that would hinder the development of science through present anti-vivisection activities.

Headquarters office was instructed to prepare a list of concise reasons why the medical profession is opposed to anti-vivisection activities. These were to be distributed to the county societies through the various councilors.

Suggestion was made that it would be well for prominent laymen in each district to write to their congressmen opposing anti-vivisection legislation.

A letter was received from the secretary of the District of Columbia medical society in regard to legislation to be brought by that society before congress. The council instructed the Legislative Committee of the Indiana State Medical Association to draw up a resolution in support of the activities of the District of Columbia medical society. The Legislative Committee was also instructed to aid the District of Columbia medical society in these activities in any way possible.

REPORTS OF STANDING COMMITTEES

Reports were made by the chairmen of the various standing committees of the state association at the council luncheon which followed:

1. Bureau of Publicity, Wm. N. Wishard.
2. Industrial and Civic Relationship, F. S. Crockett.
3. Executive Committee, A. L. Marshall.
4. Legislative and Public Policy, E. R. Zimmerman.
5. Scientific Program Committee, Jewett V. Reed.
6. Secretaries Conference Committee, J. C. Burkle.
7. Report of Diphtheria Committee, Jas. H. Stygall.
8. Report of Committee on Arrangements, Wm. S. Tomlin.
9. Report on Medical Education and Hospitals, Burton D. Myers.
10. Report on Post Graduate Study, Floyd Romberger.
11. Dr. Wm. F. King, State Health Commissioner, made a short talk inviting the officers and members of the Indiana State Medical Association to visit the new headquarters and offices of the State Board of Health.

BUREAU OF PUBLICITY

Following the formal report of the various committee chairmen, Dr. Wishard asked the council to give suggestions concerning the extension of the work of the Publicity Bureau. Dr. Bulson said that he thought the Publicity Bureau should deal more specifically in their articles with quackery in medicine, such as "cancer cures,"

etc. Dr. Myers spoke of the activity of such organizations as the American Society for the Control of Cancer, and the American Association for Medical Progress in educating the public against quackery.

Dr. Myers suggested the establishment of an Indiana branch of the American Association for Medical Progress.

Dr. Cregor spoke of the fact that the publicity articles were always educational and never controversial in nature.

Dr. Davidson said that in his opinion the Bureau of Publicity had done splendid work and that he felt the association could always count upon the judgment of that committee in handling educational and publicity matters.

SECRETARIES' CONFERENCE

In his report Dr. Burkle proposed a mid-year meeting of secretaries which will be held at Indianapolis at a time other than the state convention. Dr. Burkle also suggested that the secretaries be given a page of their own in the state journal. Following a discussion by Dr. Austin, Dr. Evans, Dr. Bulson and Dr. Leach, Dr. Crockett made the motion, seconded by Dr. Hall that the council sanction the proposed mid-year meeting of secretaries.

Dr. Bulson made a motion that was seconded and carried, that the council not only endorse such a meeting of secrtaries, but that the local expenses for holding such a state meeting be paid out of the state treasury. (This is to cover expenses of meeting hall, and other local expenses of meeting, and does not cover the actual traveling expense and hotel bills of various secretaries. The council suggests these be paid from the various county society treasuries.)

POST-GRADUATE STUDY

Dr. Romberger said that something must be done if the Indiana State Medical Association is to keep pace with the leading state societies of the country in post-graduate work. He said that the work could not be built up in one, two or three years, but must be carried on over a period of years. He suggested that the state secretary's office be made a clearing house to receive requests and fill requests for post-graduate work. He said a file of names of physicians throughout the state who are available for work should be compiled.

NON-ORGANZIED COUNTIES

The following counties were listed as dead from a medical association standpoint:

Marshall. (Due to local circumstances it is thought best not to have a Marshall county society). Most of the physicians in that county belong to and attend meetings in adjoining county societies.

Starke County—no organization.

Crawford County—no organization.

Brown County—no organization.

COUNTY SOCIETY PROBLEMS

A letter was received from the secretary of the Noble County Medical Society asking—"Why cannot your office girl mail membership cards direct to Noble County physicians?" The council was unanimous in the opinion that the cards should be mailed to the secretary and not direct to the individual members of county societies.

The following letter was received with enthusiasm concerning the recent reorganization of the Warrick County Society:

"On December 9th a meeting was called of all the M.D.'s of Warrick County, and considering the day, we were satisfied with the number present. We had a good time and all were enthusiastic. Some phoned in and others wrote saying they wanted in. We elected officers and all seemed pleased.

"We thank you for your offer to help us out, but at the present time we would love to work out our own problems, and later will be glad to have any of you drop in and advise us."

Sincerely,

P. N. HOOVER.

A verbal report of the special committee upon the disposition of White county was made to the council. The committee is composed of F. S. Crockett, 9th District; E. E. Evans, 10 District; I. E. Perry, 11 District; H. M. Hall, 13th District. The report was to the effect that White County should be taken from the 10th District and added to the 9th District, upon the request of the secretary and officers of the White County Medical Society that such a change be made.

EXECUTIVE OFFICE

The Executive Committee reported that the State Association had become a member of the Indianapolis Better Business Bureau.

After discussion, the salary of the executive secretary was authorized to be $6,000 a year from January 1, 1928, for two years, and that a bonus of $250 be made for the year 1927. Motion was made by Dr. Bulson and seconded by Dr. Gillespie, and carried.

The council went on record recommending and suggesting that each county society give one meeting a year to medical economics. Motion was made by Dr. Bulson and seconded by Dr. Weinstein.

REPORTS OF OFFICERS

Albert E. Bulson, Jr., editor of THE JOURNAL, said that he thought every councilor and every member of the state association should feel free to give constructive criticism concerning THE JOURNAL. He said THE JOURNAL was contemplating the opening of a correspondence department under the heading of "The Open Forum," wherein one could write in and discuss matters in a constructive way. Dr. Davidson said he thought it would be worth while to have a department for case reports alone.

Wm. A. Doeppers, treasurer, presented the 1927 financial report. Dr. Doeppers said he thought the books should be audited annually by an expert auditor in order that the association members may know exactly where they stand each year. Dr. Doeppers recommended that hereafter the council meetings be held after January 1, in order that the books may be closed each year on January 1, instead of on December 15. He said this would simplify the bookkeeping.

TREASURER'S REPORT

APPLICATION OF FUNDS FOR THE TWELVE MONTHS PERIOD ENDING DECEMBER 31, 1927.

INCOME:		
2,691 Member's Dues at $7	$18,837.00	
Income from Exhibits	3,437.50	
Interest on Deposits	1,080.59	
Interest on Liberty Bonds	212.50	
Total Income for Period		$23,567.59
EXPENDITURES:		
Executive Secretary Office	9,741.79	
Medical Defense	475.00	
Publicity Committee	400.09	
Public Policy	2,458.25	
Journal	5,382.00	
Other Committees	577.08	
Council	197.41	
Officers	156.50	
Annual Session	2,268.69	
Attorney	300.00	
Total Expenditure		$21,986.81
Net Income for 1927		1,580.78
Petty Cash Adjustment		191.13
Surplus at January 1, 1927		$25,243.35
Surplus at December 31, 1927		$27,015.26

ANALYSIS OF SURPLUS ACCOUNT AT DECEMBER 31, 1927

Certificate of Deposit with Meyer-Kiser Bank	$15,000.00
Liberty Bonds	5,000.00

Checking Account Balance in the Meyer-Kiser Bank	4,315.26
Petty Cash Account in Bankers Trust Co.	200.00
Contingent Fund (Held by President)	2,500.00
	$27,015.26

The treasurer's report was adopted.

Charles E. Gillespie, president elect, and George R. Daniels, president for 1928, were formally introduced to the council.

Frank W. Cregor, retiring president, made a final report upon his office, which was adopted by the council, upon motion of Dr. Daniels, seconded by Dr. Graessle.

The following statement of Palmer, head of the Palmer Chiropractic School, in regard to the amendment of the medical practice act passed at the 1927 session of the legislature, was read:

"Wisconsin, Washington (State), Connecticut, Nebraska and Minnesota were at one time medically controlled states. Chiropractic came, grew, thrived, became powerful enough to get a chiropractic bill and board. Now each of these states has passed Basic Science Bills, which means that they are now again medically controlled states. In addition to these "lost" states, we have elsewhere referred to the loss of Indiana as an "open" state to one that this winter was closed by a Medical Injunction act. The grip we had is the grip we lost."

Dr. Davidson spoke of the necessity of continued organization work and stressed the fact that the councilors through their district meetings can do much to help medical organization work if we are to maintain and hold the present high standard of medical practice in Indiana. At the next legislature we must do four-fold what we already have done, he said.

Dr. Davidson, chairman of the council, made a ruling that councilors elected by a district before the expiration of a regular councilor term shall be considered as elected to fill the unexpired portion of the three-year term *only*. Dr. Davidson held that this had been the custom of the council for many years, and that his ruling was according to the precedent that had been set down in order that there never shall be any interference with the regular three year rotation of councilor elections. On motion duly made, seconded and carried this ruling was sustained.

ELECTIONS FOR 1928

Dr. A. L. Marshall and Dr. David Ross were unanimously re-elected as members of the Executive Committee. The chairman expressed his gratitude on behalf of the council for the good work done by these men.

Dr. Wm. R. Davidson was re-elected chairman of the council for 1928.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole December 24, 1927.

THOMAS A. HENDRICKS,
Executive Secretary.

INDIANA STATE MEDICAL ASSOCIATION

STATEMENT OF INCOME AND EXPENSES FOR 1927 AS COMPARED WITH THE BUDGET

INCOME	BUDGET FIGURE	ACTUAL INCOME	INCREASE OR DECREASE	REQUESTED BY COMMITTEES	ALLOWED BY BUDGET COM.
Dues	$18,760.00	$18,837.00	$ 77.00	$	$
Exhibits	3,000.00	3,437.50	437.50		
Interest on Deposits	655.16	1,080.59	425.43		
Interest on Liberty Bonds	212.50	212.50			
TOTAL INCOME	$22,627.66	$23,567.59	$ 939.93		

EXPENSES (Executive Secretary Office)	BUDGET FIGURE	ACTUAL EXPENSES	INCREASE OR DECREASE	REQUESTED BY COMMITTEES	ALLOWED BY BUDGET COM.
Secretary's Salary	$ 5,250.00	$ 5,250.00	$	$	$
Stenographer's Salary	3,250.00	3,250.00			
Office Rent	900.00	12.00	888.00		
Light	36.00	12.00	24.00		
Towel Service	19.20	19.20			
Telephone	162.00	192.90	30.90		
Office Supplies	120.90	279.38	158.48		
Postage	225.00	177.92	47.08		
Stationery and Printing	175.00	169.93	5.07		
Telegraph and Telephone Tolls	23.50	7.77	15.73		
Traveling Expenses	214.25	119.39	94.86		
TOTAL	$10,375.85	$ 9,490.49	$ 885.36		
MEDICAL DEFENSE					
Attorney's Fees	$ 1,000.00	$ 475.00	$ 525.00	$	$
Printing					
Per Diem					
TOTAL	$ 1,000.00	$ 475.00	$ 525.00		
PUBLICITY COMMITTEE					
Clipping Service	$ 60.00	$ 67.81	$ 7.81	$	$
Stationery	200.00	87.18	112.82		
Postage	250.00	136.50	113.50		
Traveling Expenses	100.00	5.10	94.90		
Printing	200.00	99.75	100.25		
Miscellaneous	690.00	3.75	686.25		
TOTAL	$ 1,500.00	$ 400.09	$1,099.91		

PUBLIC POLICY	BUDGET FIGURE	ACTUAL EXPENSES	INCREASE OR DECREASE	REQUESTED BY COMMITTEES	ALLOWED BY BUDGET COM.
Clipping Service	$	$ 60.27	$	$	$
Postage		111.50			
Traveling Expenses		1,280.34			
Printing		81.49			
Claypool Hotel		716.57			
Telegraph and Telephone Tolls		178.08			
Radio		30.00			
TOTAL	$ 2,200.00	$ 2,458.25	$ 258.25		
JOURNAL					
Subscriptions	$ 5,360.00	$ 5.382.00	$ 22.00		
OTHER COMMITTEES					
Stationery	$ 50.00	$ 13.50	$ 36.50	$	$
Medical Education	40.00	39.87	.13		
Scientific Com. Speakers	400.00	405.91	5.91		
Industrial	50.00		50.00		
Secretary's Conference	100.00	117.80	17.80		
TOTAL	$ 640.00	$ 577.08	$ 62.92		
COUNCIL					
Traveling Expenses	$	$ 162.00	$		
Expense of Meetings		35.40			
TOTAL	$ 200.00	$ 197.41	$ 2.59		
OFFICERS (Teasurer's Office)					
Auditing	$	$ 127.50	$	$	$
Bond and Safety Box		59.00			
TOTAL	$ 200.00	$ 186.50	$ 13.50		
ANNUAL SESSION					
Rent	$ 400.00	$	400.00		
Booths and Signs	985.95	1,049.75	63.80		
Programs and Printing	150.00	276.94	126.94		
Reporters	454.61	190.00	264.61		
Clerks	20.00		20.00		
Badges	150.19	315.76	165.57		
Miscellaneous	210.00	436.24	226.24		
TOTAL	$ 2,370.75	$ 2,268.69	$ 102.06		
Attorney	360.00	303.00	57.00		
GRAND TOTAL	$24,206.60	$21,738.51	$2,468.09		

RECAPITULATION

INCOME	BUDGET FIGURE	ACTUAL INCOME	INCREASE OR DECREASE	REQUESTED BY COMMITTEES	ALLOWED BY BUDGET COM.
Dues	$18,760.00	$18,837.00	$ 77.00	$	$
Exhibits	3,000.00	3,437.50	437.50		
Interest on Deposits	655.16	1,080.59	425.43		
Interest on Liberty Bonds	212.50	212.50			
TOTAL INCOME	$22,627.66	$23,567.59	$ 939.93		

EXPENSES	BUDGET FIGURE	ACTUAL EXPENSES	INCREASE OR DECREASE	REQUESTED BY COMMITTEES	ALLOWED BY BUDGET COM.
Executive Secretary Office	$10,375.85	$ 9,490.49	$ 885.36	$	$
Medical Defense	1,000.00	475.00	525.00		
Publicity Committee	1,500.00	400.09	1,099.91		
Public Policy	2,200.00	2,458.25	258.25		
Journal	5,360.00	5,382.00	22.00		
Other Committees	640.00	577.08	62.92		
Council	200.00	197.41	2.59		
Officers	200.00	186.50	13.50		
Annual Session	2,370.75	2,268.69	102.06		
Attorney	360.00	303.00	57.00		
TOTAL	$24,206.60	$21,738.51	$2,468.09		

REPORT OF CHAIRMAN COMMITTEE OF ARRANGEMENTS. GARY SESSION 1928.

To the Council of The Indiana State Medical Association
Gentlemen:

I present herewith the preliminary report in arrangements for the Lake County session of the State Association, September 26-27-28, 1928.

It is obvious that we cannot at this time give more than a resume of our activities, but wish to advise you concerning some of the things we are doing and some that we expect to do.

MEETING PLACE

Headquarters will be established in the Gary Hotel, Sixth and Broadway, Gary. This hotel, just opened October, 1927, lends itself admirably to every activity of our meeting. Other than a proposed public health meeting on Thursday night of our session, we will not have to go outside the hotel for accommodations. (Of course, the Wednesday evening entertainment, commonly known as the "smoker" will have to be held elsewhere. More as to that feature later in the report.)

COMMERCIAL EXHIBIT

There will be no charge for the use of the Gary Hotel mezzanine floor for the commercial exhibit. This was accomplished only after much negotiation concerning which Dr. Evans can inform the Council. The only stipulation is that there shall be no nailing, sawing and all that sort of thing. This, we are assured by the executive secretary, is a thing that is not done in preparing our exhibits, hence I believe this ends the matter, so far as exhibit space is concerned.

We can also assure you that the communicating doors between the mezzanine and the Gary Commercial Club will be opened, and that the club facilities, than which there are none better, are available for our use.

We believe the settlement of these two points assures the success of the Lake County session, insofar as physical conditions are concerned.

We can assure you that ample exhibit space will be provided, as may be seen from the floor plan of the hotel, affording unequalled facilities.

GENERAL MEETING HALL

The ball room, seating more than 800, is on the second floor, easy of access via stairs and elevators. On the third floor is what we term the committee rooms. These have a seating capacity of 25 to 150. They are available for our use throughout the week.

HOUSE OF DELEGATES AND COUNCIL MEETINGS

One of these rooms will be assigned to the Council; another to the House of Delegates. The Delegate breakfast, on Friday morning, will be cared for in one of the hotel dining rooms. If it is your desire that the local committee look after arrangements for this breakfast, you will please so advise.

REGULAR HOTEL RATES ASSURED

In passing I may mention we have the assurance of the Gary Chamber of Commerce, as well as the hotels themselves, that regular rates will prevail throughout the session.

TYPE OF MEETING

At the meeting of the County Society's annual meeting, with a large attendance, over eighty per cent of the membership voted in favor of an "All General Session Meeting." We do not feel that we can provide enough clinical material for a clinical meeting, since we have no charitable hospitals in the community.

NUMBER OF ROOMS AVAILABLE

We cannot at this time give you the exact number of rooms available in our hotels, nor can we determine the exact number with bath, or the rates for same. This detail, however, will be available in ample time for THE JOURNAL announcements.

TRANSPORTATION

Trunk line railroads passing through Gary; New York Central; Pennsylvania; B. and O.; Michigan Central; Wabash and Nickel Plate, The South Shore Electric Line, South Bend to Chicago, offers a very high class service, also. In addition, we have at Hammond, the Monon, Erie, Nickel Plate, C. and O., with half hour service by traction, Hammond to Gary.

Automobile routes are too numerous to mention, some dozen or more National Trunk Lines, all traversing Lake County.

CO-OPERATION OF HOSPITALS

As to accommodations for such small clinics as may be desired, we are assured of full co-operation of all the Gary hospitals.

PUBLIC HEALTH MEETING

If such a meeting is desired, we can have the use of the Emerson auditorium, the charge for which will probably be $250.00; the place will take care of five thousand or more people comfortably.

BANQUET

As to a banquet, should this be decided on rather than the lay meeting, we can arrange for that though it probably would mean we should have to clear the assembly room in the hotel where the scientific sessions are to be held not later than 4:30 on that date. The price for such a dinner has not yet been determined. I should say $2.50, if we want an elaborate feed and program.

EXHIBIT DECORATOR

We recommend that Edgerton be placed in charge of exhibits as we are not certain we could get the work done here, as we would want it done.

The electric current is not standard, I believe it is a 25 volt affair. (Evans will give this data).

REGISTRATION AND INFORMATION

Registration desk in alcove, at east end of mezzanine; admirably placed, in plain view as one comes up, either via stairs or elevator.

Sufficient lanterns will be provided.

Registration help supplied through local society; an experienced office manager in full charge.

Information desk adjacent to registration. Persons in charge will know everything—this is absolute.

ENTERTAINMENT

Our one sweet specialty. Here is where we make more than good with you, for all the various things we promised. First and best, comes the trip through the Illinois Steel Company plant. This, as you have been advised, is made via observation train. It will take place on Wednesday afternoon, the train starting at 1:30 P. M. More than four hours will be occupied in the trip.

There is just one thing in question about this trip. It is essentially a man's trip, since if the ladies accompany us there will be no opportunity to get off the train and walk through any of the mills.

We have two or three things in consideration in this regard. One suggestion is that this be a trip for the men, the ladies to be entertained elsewhere, that afternoon. Then, at night, the ladies to have the opportunity to attend the annual smoker.

The chairman of the Ladies Committee, Mrs. O. C. Wicks, feels pretty certain she can get a special trip the ladies, for Thursday morning—a special trip through through the mills, I mean. We cannot yet say as to that.

WEDNESDAY NIGHT PARTY

The Wednesday night party, either stag or co-ed as it may be, will be the big entertainment feature of the session. This will probably be held at the Community Beach, transportation to which will be provided via the bus routes. (Transportation, of course, free to wearers of the proper badges).

LADIES' ENTERTAINMENT

We expect to care for the ladies Wednesday, Thursday and Friday; the local committee chairman is already at work, and she promises all will be royally entertained.

GOLF

We have the exclusive use of the Gary Country Club, for this Wednesday morning party, and also as many other clubs as we may need. There are about a dozen golf courses available for our party. The Gary Country Club is eighteen holes.

BADGES

This reminds me—we should like to be consulted in regards to the badge design; one of our men, H. O. Parker, has an original design. This will cost no more than the badge usually provided.

The above is but a brief resume of what you may expect from Lake County next September. We are planning great things for you and know they will work out as we are planning. Our hope is to have everything all set, ready to go, two or three months before the date of the meeting. Dr. Evans can supply any additional information needed.

E. M. SHANKLIN, M.D., Hammond,
General Chairman.

COMMITTEE ASSIGNMENTS

THE LAKE COUNTY SESSION OF THE INDIANA STATE MEDICAL ASSOCIATION

E. M. Shanklin, General Chairman.

FINANCE

E. E. Evans
E. L. Schaible
C. S. Boardman
G. F. Bicknell
F. L. Townsley
D. F. McGuire
A. V. Cole
F. R. Doll
J. R. Pugh
H. J. White
A. G. Miller
J. W. Iddings
P. J. Rosenbloom
C. M. Stoycoff

HOTELS AND RESTAURANTS

H. M. English
O. B. Nesbit
A. F. Lenzen

AUTOMOBILES AND GARAGES

H. C. Parker
H. M. Baitinger
M. Buchsbaum

PUBLICITY

S. H. Crossland

GOLF

T. B. Templin
W. E. Nichols
J. S. Niblick

ENTERTAINMENT

Ira Miltimore
F. J. McMichale
C. W. Yarrington
F. A. Gutierrez
T. W. Oberlin
C. R. Pettibone
C. C. Robinson
P. Q. Row

LADIES' ENTERTAINMENT

A. J. Lauer
N. K. Forster
E. D. Skeen
(This committee to assist the ladies' committee).

LADIES' COMMITTEE

Mrs. O. C. Wicks
Mrs. Ira Miltimore

RECEPTION

C. C. Brink
E. L. Eggers
A. H. Farley
F. H. Mervis
F. A. Malmstone

REGISTRATION

O. C. Wicks
W. M. Behn
M. H. Derian

BADGES AND BANNERS

I. J. Propper
J. C. Carver
G. L. VerPlank

PUBLIC HEALTH MEETING

O. B. Nesbit
H. C. Parker
E. E. Evans

FRATERNITY AND CLASS REUNIONS

R. N. Bills
T. F. Cotter
H. G. Cole

MILITARY SERVICE

S. J. Young
O. O. Melton

Other committees approved later.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

SCARLET FEVER STREPTOCOCCUS TOXIN-SQUIBB.—This product (New and Nonofficial Remedies, 1927, p. 375) is now marketed in packages of five vials of toxin containing, respectively, 500, 2,000, 8,000, 25,000 and 60,000 skin test doses, in packages of fifty vials of toxin, ten containing 500 skin test doses, ten containing 2,000 skin test doses, ten containing 8,000 skin test doses, ten containing 25,000 skin test doses, and ten containing 60,000 skin test doses. E. R. Squibb & Sons. New York.

SULPHARSPHENAMINE-DEPREE.—A brand of sulpharsphenamine (New and Nonofficial Remedies, 1927, p. 80). It is supplied in ampules containing, respectively, 0.1, 0.15, 0.2, 0.3, 0.4, 0.45, 0.6, 1.0, and 3.0 Gm. The DePree Co., Holland, Mich. (*Jour. A.M.A.*, Nov. 5, 1927, p. 1607).

EPHEDRINE HYDROCHLORIDE-PEMCO.—A brand of ephedrine hydrochloride—N. N. R. For a discussion of the actions, uses and dosage of ephedrine hydrochloride see *The Journal A.M.A.*, March 19, 1927, p. 925. Prophylacto Manufacturing Co., Chicago

EPHEDRINE SULPHATE—P. D. & Co.—A brand of ephedrine sulphate.—N. N. R. For a discussion of the actions, uses and dosage of ephedrine sulphate, see *The Journal, A.M.A.*, March 19, 1927, p. 925. Parke, Davis & Co., Detroit. (*Jour. A.M.A.*, November 12, 1927, p. 1693)

NASON'S PALATABLE COD LIVER OIL.—Cod Liver Oil containing 0.62 per cent of essential oils as flavoring, having a vitamin A potency such that 0.002 Gm. per day is adequate to promote the growth of young albino rats and a vitamin D potency such that 0.02 Gm. per day for eight days will cure experimental rickets in rats which have been deprived of vitamin D and of ultraviolet light. Tailby-Nason Co., Boston.

TYPHOID VACCINE.—This typhoid vaccine (New and Nonofficial Remedies, 1927, p. 367) is also marketed in packages of 30 ampules (ten complete immunizations). The Gilliland Laboratories, Inc., Marietta, Pa., (*Jour. A.M.A.*, November 19, 1927, p. 1783).

EPHEDRINE. — EPHEDRINA. — EPHEDRINE BASE. An alkaloid derived from *Ephedra equisetina*. The actions and uses of ephedrine are the same as those of the ephedrine salts. The free alkaloid is employed in mediums, such as oils, in which it is more soluble than the salts. Ephedrine occurs as an unctuous, almost colorless solid. It is soluble in alcohol, chloroform, ether and water.

EPHEDRINE-LILLY.—A brand of ephedrine—N. N. R. It is supplied in the form of Inhalant Ephedrine Compound-Lilly, containing ephedrine-Lilly, 1 per cent (by weight) in a liquid composed of menthol, 0.66 Gm.; camphor, 0.66 Gm.; oil of thyme, 0.31 cc.; liquid petrolatum to make 100 cc. Eli Lilly & Co., Indianapolis.

POLLEN EXTRACTS-CUTTER (New and Nonofficial Remedies, 1927, p. 34; *The JournalA.M.A.*, June 11, 1927, p. 1891).—Also marketed in single vial packages containing 5 cc. of a 1:100 solution. Cutter Laboratory, Berkeley, Calif.

POLLEN EXTRACTS CONCENTRATED-CUTTER. — Liquid obtained by extracting the dried pollen of plants with a liquid consisting of 67 per cent of glycerin and 33 per cent of a buffered saline solution. For a discussion of the actions, uses and dosage, see Allergic Protein Preparations, New and Nonofficial Remedies, 1927, p. 23. The following pollen extracts concentrated-Cutter are marketed in single vial packages containing 5 cc.: Alkali Weed Pollen Extract Concentrated-Cutter; All-scale Pollen Extract Concentrated-Cutter; Annual Saltbrush Pollen Extract Concentrated-Cutter; Arizona Ash Pollen Extract Concentrated-Cutter; Bermuda Grass Pollen Extract Concentrated-Cutter; Black Walnut Pollen Extract Concentrated-Cutter; Box Elder Pollen Extract Concentrated-Cutter; Burning Bush Pollen Extract Concentrated-Cutter; Canary Grass Pollen Extract Concentrated-Cutter; Careless Weed Pollen Extract Concentrated-Cutter; Coast Sagebrush Pollen Extract Concentrated-Cutter; Cocklebur Pollen Extract Concentrated Cutter; Common Ragweed Pollen Extract Concentrated-Cutter; Corn Pollen Extract Concentrated-Cutter; Cottonwood Pollen Extract Concentrated-Cutter; False Ragweed Pollen Extract Concentrated-Cutter; Foxtail Grass Pollen Extract Concentrated-Cutter; Giant Ragweed Pollen Extract Concentrated-Cutter; Johnson Grass Pollen Extract Concentrated-Cutter; June Grass Pollen Extract

Concentrated-Cutter; Lamb's Quarters Pollen Extract Concentrated-Cutter; Marsh Elder Pollen Extract Concentrated-Cutter; Mountain Cedar Pollen Extract Concentrated-Cutter; Mugwort Pollen Extract Concentrated-Cutter; Oak Pollen Extract Concentrated-Cutter; Olive Pollen Extract Concentrated-Cutter; Orchard Grass Pollen Extract Concentrated-Cutter; Plantain Pollen Extract Concentrated-Cutter; Red Root Pigweed Pollen Extract Concentrated-Cutter; Red Top Pollen Extract Concentrated-Cutter; Russian Thistle Pollen Extract Concentrated-Cutter; Rye Grass Pollen Extract Concentrated-Cutter; Sagebrush Pollen Extract Concentrated-Cutter; Shad Scale Pollen Extract Concentrated-Cutter; Timothy Pollen Extract Concentrated-Cutter; Tumbleweed Pollen Extract Concentrated-Cutter; Velvet Grass Pollen Extract Concentrated-Cutter; Western Ragweed Pollen Extract Concentrated-Cutter; Western Waterhemp Pollen Extract Concentrated-Cutter; Wild Oat Pollen Extract Concentrated-Cutter; Yellow Dock Pollen Extract Concentrated-Cutter. Cutter Laboratory, Berkeley, Calif. (*Jour. A.M.A.*, November 26, 1927, p. 1873).

PROPAGANDA FOR REFORM

BLUEBERRY LEAF EXTRACT.—The Council on Pharmacy and Chemistry publishes a preliminary report on a blueberry leaf extract which has been proposed for use in the treatment of diabetes. A report on this product was read at the last meeting of the American Medical Association by F. M. Allen, who had continued the work begun in Germany by Wagner and others. The product used by Allen was made by E. R. Squibb & Sons; it is not being marketed and will not be offered to physicians in general until its usefulness has been demonstrated. The Council published its preliminary report to call attention to the possible usefulness of the blueberry leaf extract used by Allen. At the same time the Council points out that thus far no standards have been developed which will insure a uniform product; that the actual value of the product in the treatment of diabetes has not yet been proved; and that such proof must come from workers who have the necessary clinical opportunities and laboratory facilities on which to base judgment. (*Jour. A M.A.*, November 5, 1927, p. 1607).

INTRODUCING NEW DRUGS.—The report on blueberry leaf extract which the Council on Pharmacy and Chemistry publishes, illustrates the praiseworthy and increasing tendency on the part of the large pharmaceutic firms to adopt the ideal method of introducing a new drug, namely, demonstration of the drug's chemical identity and uniformity; report of animal experiments giving promise of therapeutic value; report of clinical trials under the auspices of the discoverer; and provision for confirmatory study of the drug's therapeutic worth by independent investigation. What a contrast to the unscientific and haphazard flooding of the market with new and untried drugs that formerly obtained here and still obtains abroad! The change has arisen from the increasingly critical attitude of the American medical profession. This, it seems reasonable to believe, is due to the faithful and persistent work of the Council on Pharmacy and Chemistry. (*Jour. A.M.A.*, November 5, 1927, p. 1610)

THE MOUNT CLEMENS BATHS.—The Mount Clemens mineral springs are unusually strong solutions of salines, giving off the pungent odor of hydrogen sulphide. They are not thermal springs; the water is heated in bath houses. Patients with chronic rheumatic, neuritic and neuralgic disturbances are especially likely to be benefited by such baths. The use of hot procedures is dangerous in all conditions of profound general weakness, enfeeblement of the heart and degeneration of the arteries. Patients with a tendency to rise in temperature should also not be subjected to heat procedures. Medical supervision is absolutely required to secure good results. What folly it is for people to go to Mount Clemens and other bathing resorts, jump into hot mineral baths and drink a lot of strong saline water, trusting to Providence to take care of the rest! (*Jour. A.M.A.*, November 5, 1927, p. 1625).

SCARLET FEVER ANTITOXIN.—The advantages of giving commercial scarlet fever antitoxin are necessarily dependent on the accuracy of standardization of the preparation and its use in adequate dosage. The chief advantage of giving commercial scarlet fever antitoxin as a preventive is that the administration of 100,000 neutralizing units prevents the development of clinical scarlet fever in a susceptible person already infected with scarlet fever streptococci but not yet sick. This protection is transient and, as soon as the antitoxin is eliminated from the body, the individual may again become susceptible to scarlet fever and should be more permanently protected by active immunization with graduated doses of the toxin. The advantages of giving scarlet fever antitoxin are: 1. If an adequate dose is given, the toxin in the patient's body is neutralized and death from toxemia is prevented. 2. If the antitoxin is given early, both the incidence and the severity of complications are reduced. 3. As a rule, patients who receive scarlet fever antitoxin early in the disease get rid of the scarlet fever streptococci sooner than those who do not receive the antitoxin. (*Jour. A.M.A.*, November 5, 1927, p. 1625).

KLAIBER SUBAQUEOUS INTESTINAL BATH APPARATUS NOT ACCEPTABLE.—The Council on Physical Therapy reports that this apparatus is not acceptable for inclusion in the accepted list of devices for physical therapy. It is stated to be a device for irrigating the colon while the patient is immersed in water with the aim thereby of increasing abdominal pressure to compensate in part for the increased pressure within the colon. The Council reports that the apparatus is apparently made for specific purposes and the principle of operation is novel and suggests therapeutic advantages. The Council declares the apparatus unacceptable because (1) sufficient evidence has not been presented to show that this complicated apparatus will accomplish more than simple existing devices of the same general nature; (2) because therapeutic claims not well warranted and unscientific statements are made in the advertising; and (3) because adequate instruction in the proper use of the apparatus and method and adequate exposition of the possible dangers and limitations are not given. (*Jour. A.M.A.*, November 12, 1927, p. 1693.

SOLUTION OF PITUITARY FOR INDUCTION OF LABOR.—The application of solution of pituitary to the nasal mucous membrane as a means of induction of labor has been reported on. Under direct vision with reflected light and the use of a speculum, the nose is cleansed and a pledget of cotton, moistened with 1.25 cc. of solution of pituitary, is inserted snugly under the anterior end of the inferior turbinate of the nostril. At the end of an hour or two the pledget is withdrawn. If necessary, a fresh pledget is applied to the other nostril. The procedure is reported to have been successful in every one of fifty-six cases in which it was used. In a series of twenty-four cases to test the method in normal pregnant women during the last month of pregnancy and at term, there were nine failures. All the babies were born alive. (*Jour. A.M.A.*, November 12, 1927, p. 1696).

WARNINK'S ADVOCAAT NOT ACCEPTABLE FOR N. N. R.—"Warnink's Advocaat" (Julius Wile, Sons & Co., New York, distributors) is an egg nog declared to be imported from Holland and to contain 18 per cent of alcohol in the form of brandy and three minims of Fowler's solution to each fluid ounce. The Council declared the preparation unacceptable for New and Nonofficial Remedies because the name is not descriptive of the potent constituents—potassium arsenite and alcohol—of the mixture and because the administration of an alcoholic "tonic" in combination with fixed amounts of arsenic and under a noninforming name is irrational, while the method of marketing is likely to lead to its ill advised and harmful use by the public. (*Jour. A.M.A.*, November 12, 1927, p. 1711).

PHILIP NEWTON'S MATAMEL.—"Matamel" has for two or three years past been exploited by one Philip Newton. It is claimed to be—and probably is—the concentrated sap of the maguey plant. According to the advertising put out by Newton, both under his own name and under his trade name "Newton Laboratories, Inc.," Matamel has been puffed as a cure for Bright's disease, "bladder trouble" and hypertrophy of the prostrate. In September, 1926, the Newton Laboratories, Inc., as well as Philip Newton himself, were called on by the postal authorities to show cause why a fraud order should not be issued against them. To the disgrace of the medical profession, Newton was able to produce a dozen or more testimonials from physicians in defense of his quackery. Obviously realizing that sooner or later the mails would be closed to him, Newton has determined to discontinue the mail-order business. This does not mean that the public is no longer to be humbugged by the Matamel quackery. It means that Newton has to split his profits with the drug stores and will sell it through them. (*Jour. A.M.A.*, November 12, 1927, p. 1712).

VACCINE TREATMENT FOR INFECTIONS OF UPPER RESPIRATORY TRACT.—Upper respiratory infections, acute or chronic, are due to bacterial infection, usually of a mixed type. Various organisms, as the pneumococcus, streptococcus, staphylococcus, influenza bacillus and *Micrococcus catarrhalis*, may be demonstrated as normal inhabitants in the nasopharyngeal secretions of healthy persons. During seasonal variations or epidemics, some particular variety or group may predominate, particularly some type of the pneumococcus or the influenza bacillus. Bacteriologic examination in the upper respiratory infections does not reveal one specific organism as several varieties are present, perhaps some one predominating, depending on circumstances. The presence of absence of symptoms interpreted as disease depends mainly on the virulence of the infecting organisms present and the resistance of the individual. It is the latter factor that vaccine therapy is supposed to assist. The results of such treatment must be determined by immunity tests or by clinical results. Advocates of vaccine therapy, either autogenous or stock vaccine, are not able to advance laboratory proof that is convincing, but prefer to depend on the clinical data, which is notoriously uncertain. Colds, coryza, upper respiratory infections and the like may respond so promptly to the usual drug therapy or even to no treatment whatever that it is impossible and unfair to make the clinical results a basis of proof for the justification of vaccine therapy. (*Jour. A.M.A.*, November 12, 1927, p. 1713).

BROADCASTING BUNCOMBE.—In the not very distant past, the quack and the faddist had the entree—at advertising rates—to the majority of the newspapers of the country, and thus was made the point of contact between sucker and suckee. Today the majority of newspapers of wide circulation do not cater to the business of the medical faddist or the quack. With that avenue closed, it was but natural that radio advertising should be taken up. Broadcasting in the United States is a commercial venture. Generally speaking, the broadcasting station is out to sell time on the air. It is natural, therefore, that these stations should look with favor on any commercial organization that is willing to pay the price the station asks for puffing its particular line of goods. Thus it is that the radio fans have their ears assailed almost nightly with some pseudomedical fad, or the exploitation of some crude piece of quackery. One of the earliest entrants into this field was the "Palmer School of Chiropractic," which has its own broadcasting station, WOC, at Davenport, Iowa. Then there is that enterprising quack who specialized on "rejuvenation" operations and who owns and operates KFKB. Station WHT some months ago was broadcasting with great regularity the alleged virtues of a "patent medicine," Salicon. WJAZ, not so long since, was telling the radio world the marvels of that ingenious faker Professor Scholder. Over KTNT of Muscatine, Iowa, comes the story of the "Tangley Institute," which has a sure-fire cure for varicose veins. WJBT of Chicago has described, via the ether, the marvels and virtues of the magic horse collar, the "I-on-a-co." The Voice of Labor—WCFL—permits Dr. Percy Lemon Clark of Chicago, to broadcast health misinformation. Over this same station—WCFL—comes the "Restoro," a base imitation of Wilshire's magic horse collar. (*Jour. A.M.A.*, November 19, 1927, p. 1786).

THE MEDICAL PROFESSION AND COSMETICS.—The American Druggist, which, according to newspaper reports, has been added to the series of publications owned and controlled by the International Publications, Inc., of which William Randolph Hearst is president, contains an article by one Alice (Hyphen) Esther Garvin, who, apparently has developed the quaint notion that the American Medical Association is endeavoring to secure legislation which will make it necessary for druggists to sell cosmetic preparations only on prescription. This extravagant straw man the lady then devastates with ridicule. The American Medical Association is holding strictly to its policy of protection of the public in all matters related to health, asking only that the presence of dangerous ingredients in the few cosmetic preparations that contain them be so indicated as to give the public the opportunity of knowing what risks it may run in using them. (*Jour. A.M.A.*, November 19, 1927, p. 1787).

HORACE D. REYNOLDS—QUACK.—Ohio papers of October 26, 1927, reported that Horace D. Reynolds of Cleveland, was being held without bond when two victims died and four others became seriously ill following the administration of Reynolds' so-called serum. Reynolds and those associated with him have operated quack offices in various large cities—Chicago, Cleveland, Pittsburgh, Buffalo, Detroit, etc.—that are described as "Research Laboratories." In Chicago Reynolds' concern was known as the "State Research Laboratories." This laboratory, which has been known as the "Blood Cell Serum Laboratory" flourished until the Chicago Tribune exposed the Reynolds quackery and practically drove it from the city. (*Jour. A.M.A.*, November 19, 1927, p. 1801).

DIET FOR PERNICIOUS ANEMIA.—The essential feature of the Minot and Murphy liver diet in pernicious anemia is the administration daily of about 200 Gm. of cooked weight of mammalian liver. This is combined with generous amounts of fruits and vegetables, containing from 5 to 10 per cent of carbohydrate, and red muscle meat. A reading of the work of Minot and Murphy leaves the impression that diet is more or less specific in pernicious anemia and only adjuvant in secondary anemia. (*Jour. A.M.A.*, November 19, 1927, p. 1803).

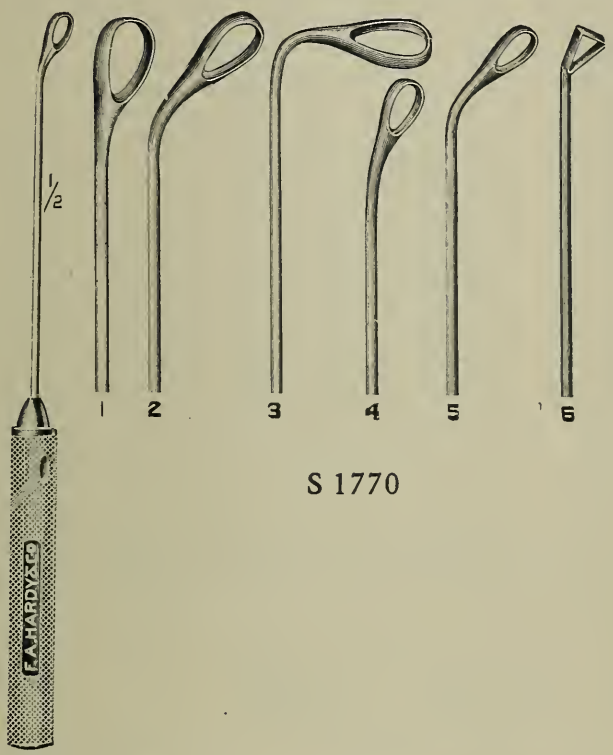
PYRIDIUM.—Pyridium appears to have been originated by one Professor Ostromislenski, who came from Russia several years ago to give America the benefit of his researches. In a circular issued by Merck & Co. the preparation is said to be "a colloidal condensation product of Phenyl-Azo-Diamino-Pyridine Hydrochloride as prepared by Prof. Ostromislenski" and it is recommended in the treatment of "Genito-Urinary Infections especially Gonorrhea." Apparently the only evidence for the value of Pyridium is contained in a book by Ostromislenski. Merck & Co. has not presented the product to the Council on Pharmacy and Chemistry for determination of its acceptability for New and Nonofficial Remedies. (*Jour. A.M.A.*, November 19, 1927, p. 1803).

SEEQIT.—This is an analgesic tablet put on the market by a concern known as Laboratories JAQ Inc., of New York City. The method of introducing this nostrum is unusual. Instead of advertising the product in the newspapers and placing it on the shelves of the drug stores, Laboratories JAQ Inc. circularize women's colleges and such large industrial concerns as employ many women. Seeqit is described as "the great industrial tablet which will create 100 per cent efficiency and bring

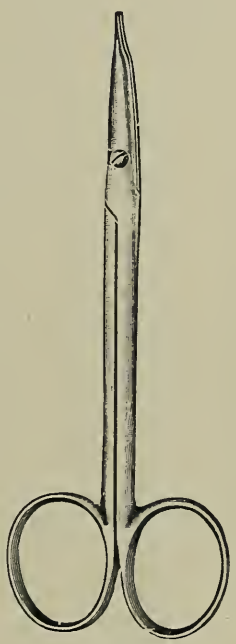
(Continued on adv. page xx)

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TRUTH ABOUT MEDICINES

(Continued from page 50)

health and happiness to your women workers." The A. M. A. Chemical Laboratory analyzed Seeqit and concluded that each tablet consists essentially of 0.24 Gm. (approximately 3¾ grains) of amidopyrine (Pyramidon) and 0.07 Gm. (approximately 1 grain) of caffeine, with excipients. (*Jour. A.M.A.*, November 26, 1927, p. 1891).

Formula RA-3.—This is a rather obvious piece of quackery. In February, 1926, John R. Willis, director of the concern that puts out RA-3, described the product as a newly discovered, absolutely harmless, fully guaranteed, therapeutic preparation which contains minute quantities of Radium. It was stated that these minute quantities of Radium, "together with important other ingredients," which "medical science has discovered, has a peculiar power of clearing the brain, toning up the entire system, nerves, muscles, organs, bringing about a healthy buoyance and vigor that makes you feel like a new man." In July, 1926, Mr. Willis described the product as a preparation containing "all the important constituents of the outsides of the grains and vegetables . . ." (*Jour. A.M.A.*, November 26, 1927, p. 1893).

Auto-Hemic Therapy.—One of the ventures of L. D. Rogers is his "Auto-Hemic Serum," with its inevitable "National Society of Auto-Hemic Practitioners." According to Rogers, Auto-Hemic Therapy "consists in giving the patient a solution made by attenuating, hemolizing, incubating and potentizing a few drops of his or her own blood, and administering it according to a refind technic developed by" L. D. Rogers. Those interested can, by sending Rogers "$100 cash in advance," get a mail-order course on this marvel. (*Jour. A.M.A.*, November 26, 1927, p. 1893).

BOOK REVIEWS

Lippincott's Pocket Formulary. By George E. Rehberger, M.D., author of Lippincott's Quick Reference Book. J. B. Lippincott Company, Philadelphia and London. 1927. Cloth. Price, $3.50.

In reality this is a pocket edition of a popular work on therapeutics. Among other things it contains a list of the drugs and preparations of the U. S. Pharmacopeia with their solubilities, dosage and uses; drugs and preparations of the National Formulary, and New and Non-official Remedies. In addition there are tables of relative weights and measures, and the apothecary and metric systems, tables of heights and weights, a list of incompatabilities, urinalysis, etc. Diseases and disease conditions are listed alphabetically, and under each are formularies of drugs or combinations of drugs that have proved valuable in treatment.

How to Make the Periodic Health Examination. By Eugene Lyman Fisk, M.D., Medical Director, Life Extension Institute, and J. Ramser Crawford, M.D., Assistant Medical Director, Life Extension Institute. The MacMillan Company, New York. 1927. Cloth. Price, $4.00.

As has been pointed out by the surgeon general of the United States Army, who has written the foreword for this book, periodic physical examinations are of extremely great importance in the maintenance of health. The physical examination of apparently healthy persons must be systematically and thoroughly performed in order that injurious habits of living and slight or beginning functional structural abnormalities may be revealed. The early detection of these conditions permits the application of corrective measures at a time when they will be most effective in preventing serious health impairment. This book provides a method of conducting systematic examination which will obviate error and assure the detection of obscure but vital defects.

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THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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ORIGINAL ARTICLES

HEART*

HENRY A. CHRISTIAN, M.D.
BOSTON, MASS.

Case 1.—This particular man is a type of oedematous cardiac case. You can see the marked oedema of his hands and there is a corresponding oedema of his legs. Like so many of these cases, this is not his first break in compensation. He came to the hospital some time in August, I believe, of this past summer; but he was here a year ago, so he had been out only about six months. He was a traffic officer. Perhaps some of you who live in Indianapolis may recognize him as the fellow who made you obey the rules sometimes when you did not want to. He is 49 years of age. He came to the hospital on April 18, 1926, complaining of shortness of breath, generalized oedema weakness and debility, which had developed about a month prior to that. He stayed here for several months, got rid of the oedema, and was in such good condition that he went home; but like so many of our patients, he found it hard to take thorough rest; he had to exercise more than he himself knew was good for him, and as a result he had another break in compensation. He was out of the hospital about eight months and then came back.

What are the important points in the study of such a case? The urine of these patients is full of albumen; there are casts of all sorts, and their phthalein excretion is reduced. This particular patient had 20 per cent phthalein excretion in two hours; blood urea nitrogen, 9 to 11 mgm. per 100 c.c. of blood.

As to the physical examination, I would like to impress upon you the importance of using your eyes and your hands, because inspection and palpation give you a lot of important information. We have five senses to use and sometimes we do not use them in the right way; we do not use them most intelligently. Of course, taste plays a very small part in diagnosis; the sense of smell a very small part; but what you can see, and feel, and hear is of great importance. In cardiac cases what we see and what we feel is of first importance; what we hear often is of secondary importance. In most cardiac cases the diagnosis should be made before you use the stethoscope, and what you hear is confirmatory of what may have been doubtful up to that time.

The important thing in a cardiac case is to find out the size of the heart. You can do it most accurately with the x-ray, but you usually can dispense with the x-ray. When you can locate the apex impulse, then you have only one further thing to do in determining the size of the heart, and that is to determine whether it is displaced—this you do by percussion. This patient is rather stout and has not a very forcible apex impulse; I doubt whether you can see it. As is often the case, it is very difficult to feel, but you can feel the impulse and you know at once from where you feel it that he has a heart, as far as the left border is concerned, that is well out beyond where it should be. Then you should confirm that by percussion. Except in very thin-chested people, you have to depend on percussion entirely for the right border. In some people you can see or feel the action of the heart to the right of the sternum and tell the size, but usually you can make it out only by percussion. Percussion is always for you, never for the audience. If you percuss loud enough to demonstrate anything to anybody but yourself you have lost a great deal of what you should accomplish by percussion, because you have made too much noise.

Now, we want to know whether this man has an enlarged heart. He has, as you can judge by percussion and by feeling his impulse beat. He evidently has oedema and he has a lot of fluid in his abdomen. I percussed him yesterday afternoon and he has some fluid in his chest on the right side. He has a palpable liver and all these are evidences of passive congestion.

The question of etiology is always of interest, both from the point of view of diagnosis and of treatment. What have we in this man that would suggest the cause of his condition? Let me give you a little bit more from his notes. A month before he came into the hospital for the first time he noticed that he was short of breath and weak. He went home intending to rest, but was called out of town by illness in the family and was gone three weeks. When he returned the oedema had

*Clinic presented at the Indianapolis session of the Indiana State Medical Association, September, 1927.

started, he was much worse, and came into the hospital. Isn't that human nature? So often we plan something for ourselves or our patients, and then let our plans be upset by some extraneous circumstance. This man attended to somebody else in illness, and he himself suffered.

One interesting thing was that when he came in the first time they thought his heart was fibrillating; he had an irregular rhythm; now it is regular. We get very little to suggest the etiology in these notes, but there may be something we do not have here. They did find a strongly positive Wassermann reaction, and the question was whether it was a luetic cardiac condition or some other cause. He was put on antiluetic treatment when he was here before, and he improved. At the same time he was treated as a cardiac case, and whether the improvement came from the antiluetic treatment or the cardiac treatment, we do not know. My experience has been that these patients very rarely have luetic myocardial lesions.

This man left the hospital on November 1, 1926, in good condition and did very well until three weeks before readmission on August 25, 1927, when he had a recurrence of symptoms, shortness of breath, oedema, and weakness.

This type of patient may or may not show murmurs. Whether or not they show murmurs has very little to do with the diagnosis or with the treatment. Of course, with a positive Wassermann you have to exclude aortic lesions. You can look at this man and see the absence of pulsation in his neck and be pretty sure he has not aortic insufficiency, and when you feel his pulse you find he has a very small radial pulse, and that confirms you also in the belief that he has not aortic insufficiency. That is, if he has not also a mitral stenosis. If he had a mitral stenosis and aortic insufficiency together, he might not have the pulse of aortic insufficiency because the stenosis often prevents collapse in the pulse with aortic insufficiency. When you listen you find his heart sounds are inconspicuous, are tic-tac in quality, there is no murmur at the apex, no murmur at the base. The second sounds at the base are not very conspicuous, and those on the left side in the pulmonic area are slightly louder than those on the right side in the aortic area. There is no murmur of aortic insufficiency.

The interesting thing in such a case from our point of view is the cause, if we can get at it from the point of view of treatment. If there is an etiologic factor, that can be treated. This man has a positive Wasserman and very wisely he received antiluetic treatment. Often the therapeutic test is the only way we have to determine whether a patient has a luetic lesion which causes the disturbance that we note when we take the history and make the physical examination. As I said very rarely in my experience do these patients have a luetic heart lesion. A luetic myocardial lesion is rare in Boston. Of course, at Ann Arbor, Dr. Warthin finds it frequently. That is one of those curious discrepancies we have. Whether syphilis is different in Michigan from what it is in Boston, I do not know. We cannot often find spirochaetes in the heart muscle in Boston. A relatively small percentage of our patients suffering from myocardial disease have a positive Wassermann reaction, and we do not get results from antiluetic treatment, and even when they do have other evidences of syphilis we do not get much result. So we come back to what to do with this man as a cardiac case. The only evidence of cardiac lesion in this particular case is the cardiac enlargement, with oedema, and in these cases usually digitalis with diuretics should produce results. In this patient it has not apparently been very successful. Whether if they pushed the digitalis more vigorously and used the diuretics in larger variety they would accomplish anything, trial only will show. I would like to say this, however, that in the case of a patient who has oedema such as this, where digitalis and diuretics have failed to give results, we have in reserve mechanical drainage. That patient has not very much fluid in his pleural cavity, but sometimes if a relatively small amount is drawn off it makes a little less respiratory and circulatory burden, and it is wise in those cases to tap the chest. Sometimes you will be tremendously surprised at the amount of fluid you can draw from the chest, where the physical signs do not indicate very much fluid. So I should in such a case tap the chest and get as much fluid off as possible. The same thing applies to the abdomen. It is questionable here if you would succeed in getting any appreciable amount of fluid and at present I would not tap his abdomen. You can mechanically draw off fluid through the subcutaneous tissues. A Southey tube inserted into the subcutaneous tissue will often yield a surprising amount of fluid. If in this patient I did not get diuresis by means of digitalis and diuretics, I would mechanically remove the fluid by a Southey tube or by incision of the leg. It is surprising how much fluid will run a long way to get out a small hole in a man's leg. You can drain from the level of the diaphragm by incision just above the ankle.

To sum it up, this case seems to be one of cardiac disturbance which is essentially a myocardial insufficiency—the muscle is at fault. The valves seem to be all right.

Has that patient hypertension? His blood pressure on this admission and on his former admission, was within normal range. My colleague, Richard Cabot, calls that hypertensive heart disease. If the patient of this type does not have blood pressure elevation when you see him, Dr. Cabot says he had it in the past. You cannot prove he did not have it, but I have seen a great

many of these patients who under various observations by various physicians never had hypertension, but who evidently had that sort of heart disturbance.

The ophthalmoscope helps us in these cases in studying their blood vessels. I looked at this man's eyegrounds yesterday afternoon and he showed very little evidence of any vascular disease in his retinal arteries. When these patients do show marked retinal arterial disturbance, even though their blood pressure is low at the time, we are sure they had had high blood pressure in the past, because high blood pressure continued for any great length of time leaves its mark on the small vessels of the eyegrounds and they represent what is going on in the general vascular system. It has been very well shown by Foster of New York that of patients who had high blood pressure in eclampsia whose blood pressure came down and the patients were well, a year later a large percentage showed retinal vascular lesions, an examination of the eyegrounds indicated that the hypertension of the past had left its mark in the present changes of the eyegrounds. This man does not show the eyeground changes which you ordinarily find with existing or past hypertension.

Case 2.—In contrast with the first patient I have brought in another where the condition of the heart is much the same, but the oedema has not been such a manifest feature. This patient is 75 years old; he has been in the hospital once before and got along pretty well. He was discharged for an interval of six or eight months, and now he has much the same cardiac symptoms. He was admitted the first time on August 26, 1926, complaining of shortness of breath, weakness, a persistent cough, and swelling of the extremities. Eight months before he came to the hospital the first time he had an attack of influenza followed by pneumonia, and has never been well since. That I think, represents a fairly frequent etiological factor in the development of this type of myocardial disease. I have seen a great many of these patients who were well up to the time of an attack of influenza complicated by pneumonia—and all severe influenza cases have pneumonia—and that combination started a train of disturbances in the heart. I have followed these cases through their acute attack and they did not behave, as far as their circulation was concerned, in an abnormal way. They showed no evidences of cardiac disease; upon examination, the pulse was as good, the rate was no more rapid than you would expect in a normal individual with the same pulmonary involvement; and yet a year later you see the same patient and he has evidences of cardiac failure, the heart is enlarged, etc. I have seen that so often that I have a strong belief that broncho-pneumonia and lobar pneumonia are important etiologic factors in producing myocardial disease, and this patient illustrates that possibility. He had pneumonia eight months before his cardiac symptoms developed. He never got entirely over his influenza and pneumonia, and gradually these cardiac symptoms developed.

He lived 71 of his 75 years in remarkably good health, always very active. There does not seem to be much in this man's past history except pneumonia and the possibility of senile degenerative changes to be responsible for his condition. He also has some evidence in his mental capacity of degenerative changes in his brain.

When you look at him, the first striking thing is the absence of the oedema that was so prominent in the other patient. This man has slight oedema, but largely in the dependent parts, probably not generalized. Another interesting thing is that though he has these evidences of senile degenerative changes, he is relatively free from arteriosclerosis; his arteries are a little thickened, but not very abnormal. You can tell a good deal about the arteries by watching the pulsation. If you see the beat take place laterally you know the patient has a type of degenerative change, that the blood vessels are lengthened, are somewhat tortuous. You can trace this man's radial artery as all of his arteries. They are not beaded, they are not calcified, nor extensively sclerosed. His eyegrounds show the same thing, that there are no extensive small vessel changes.

It happens that these patients I am showing are not cases of valvular disease, so that on palpation over the precordium you do not get the thrills that you would get in patients with cardiac valvular disease, and consequently you cannot make a diagnosis of what you are going to hear on the basis of what you feel. When you can feel thrills you can almost make as good a diagnosis of valve diseases as you can when you listen with the stethoscope. I have been much interested with my students, both undergraduate and graduate, in finding out how little the average man can feel because he has not trained his hands as much as his ears; and how little he sees because he does not look; and how much sometimes can be made out by the sense of touch—the sense of feeling—that somebody else has missed. I always like to recall the statement of Dr. Osler, that in one year he saw three patients with aneurysm of the arch of the aorta, in all of whom the diagnosis was made for the first time by himself because he was the first man who in making the examination took off the patient's shirt. That was in the days of the "boiled shirt," and when he removed this man's boiled shirt he found visible palpable pulsation in the proper place for an aneurysm. Three times in one year he states he had that experience—taking off a patient's shirt and immediately making a diagnosis that all the physicians might have made had they taken off the patient's shirt. That illustrates what

I mean by looking at your patients and feeling them.

I think if you palpate with your entire hand you get more than by palpating with your finger tips. My finger tips are not as sensitive as the palm of my hand just below my fingers. There is another advantage in using the whole hand—you cover a larger area and you can feel things that you may not otherwise get your hand on. It always pays to feel carefully for the apex impulse, because in a lot of these patients with the emphysematous type of chest the percussion of the cardiac area is difficult. Where you can feel the apex impulse you can depend upon that more than upon the sounds you get through the stethoscope. You can nearly always determine the size of a man's heart, as to whether or not it is enlarged, without depending upon the x-ray. That is important to those who do not practice in a hospital, and it is also important to those who do practice in a hospital. You should not be too dependent upon the x-ray because when you see patients outside of the hospital you are handicapped. Learn how to use your simple senses, and then confirm your findings by more delicate methods; but always make up your mind what is there from simple methods before you go to the more complex and soon you will be able to observe a great deal more without the more complicated methods.

I did not bring in this particular patient for the purpose of discussing therapeutics, but simply to contrast him with the other patient from the point of view that some of these striking cases have this marked oedema, and another patient of exactly the same type—this man's heart is the same size, he has the same range of blood pressure, about the same urinary picture—phthalein 30, blood urea nitrogen 14, his urine shows albumen and occasional casts. He is not so very different from the other man, yet he does not have oedema, while the other man had oedema early in his disease and this man did not. You may ask why that is so? You need not ask me because I do not know. But I want to impress upon you this point—that there is a type of cardiac case in which the outstanding feature is a generalized oedema. It is usually the patient with a heart that is enlarged, and that may be the only abnormality determined on physical examination of his heart. If you treat it as a renal case you do not get such good results; if you treat it as a cardiac case you do get good results provided the patient has not a heart muscle that no longer will respond.

To illustrate how dependent our students, our hospital officers and the members of our visiting staff become on the more complicated methods of diagnosis, all you have to do is to walk into a ward and sit down by the bed and look at the patient, and then begin to tell them what you see; then feel the patient and tell them what you feel; then stop there and tell the group as far as you can what the physical abnormalities of the patient are. You always see a definite expression of surprise on the faces of those who have just been using the fluoroscope or some other diagnostic method that requires a good deal of time and highly developed technique and a lot of expenditure of money when what you have said as the result of this very simple examination is the same as what they have made out by these more complicated methods. Then go further and carry out the more delicate methods of physical examination, take everything that has been done in the wards by the various internists and by special methods, and evaluate those. You will find something added each time, but not so much added but that you might have been pretty well off in the diagnosis and treatment of that patient, if he had lived in a remote part of the country away from hospitals, specialists, x-rays, etc. You could tell by your simple senses what is the matter with the patient, and consequently you could intelligently advise treatment that could be carried on without the patient leaving his home.

Case 3.—This is a much more complicated situation and it is very much more difficult to make a satisfactory diagnosis. I do not know that we will succeed in doing that.

This young lady is ten years old; pulse 49. You hear her coughing and that sounds like the cough of cardiac disability. You can see she has a rather puffy, pale face, perhaps not so markedly puffy as it has been. I am told that at times her face has been oedematous and then it has cleared up. There is no oedema of the hands. You can see a mass in the upper abdomen, evidently an enlarged liver. I believe at one time this patient had a palpable spleen. I could not feel it yesterday afternoon. You can see there is some oedema of the lower extremities, but that has been more marked than at present. She is dull to percussion in the dependent parts of her abdomen and has a slight suggestion of a fluid wave. I think probably there is a moderate amount of fluid in the abdomen. When we come to the heart, she has a much enlarged heart. It is about as large, if not larger, proportionate to the patient than these others. The apex impulse is well out to the midaxillary line. It is not displaced because there is considerable increase in dulness to the right of the sternum; the right border three fingers to the right of the midsternal line. You can feel a diffuse impulse all over her precordium. When she breathes you can feel the vibrations of chronic bronchitis, but you can not feel thrills in the cardiac area. She has a very definite systolic murmur in the apex region. You can hear that same sort of murmur at the base. It is just loud enough to be transmitted beyond the cardiac borders. She has a moderate degree of dulness at the right

base of her lungs, so she has a little fluid at the base on that side; rales can be heard over both bases.

When she first came in her urine was made out to be clear and negative; then, later on, she developed a very considerable amount of albumen, running 2 plus, 3 plus, 2 plus, etc. Total nonprotein nitrogen is 27.9. Renal function is not very much disturbed. She does have a large amount of albumen.

Another point in the diagnosis is this: Are you going to consider this patient as having primary cardiac disease wth a subsequent renal dsturbance or did she have first a nephritis and a consequent cardiac hypertrophy and insufficiency? I do not know that we can decide that, for this reason. We know that children very often have glomerular lesions in this type of nephritis with oedema, far more frequently than adults. You get very cautious about saying the kidney is normal in these children. Why? Beçause in the past you have often said it was normal and then at autopsy found you were wrong. So it is pretty safe in these children with a little oedema to think of glomerular lesions. But when we look at the urine reports of this patient it is striking that there were very few blood cells, and they are apt to be found in patients with a glomerular lesion, so that the mass of evidence perhaps is against a glomerular lesion.

The important point illustrated in this patient is that this type of cardiac lesion, simple hypertrophy, does not occur solely in the adult; it occurs at times in children, even in very young children, occasionally in the newborn. Cardiac hypertrophy without evidences of valve lesion, without any evidences of hypertension, is found in the young, but is much more frequent in older adults than in children. That reduces to a certain extent the importance of infection with syphilis. These children with cardiac hypertrophy are not congenital syphilitics. And it also reduces the importance of hypertension. If children can be born with hypertrophied hearts, acquiring the lesion in utero, as they apparently do in some instances, and if it is not infrequent to find them a year or so after they are born, it is not probable that hypertension has much to do with it. That type of heart does occur in young people, and when you find an enlarged heart you do not have to hunt for obscure evidence of valve lesion or signs of pericarditis, because the cause is in the heart muscle and the only thing that shows it is the enlarged heart.

Question: What is the etiology of this case?

Dr. Christian: I have not the slightest idea. This patient had one infectious disease, chickenpox, with good recovery. There is one feature in the symptomatology of this case, and that is that this patient has had a great deal of abdominal symptomatology. Digestive trouble began early and she came in complaining of persistent vomiting and shortness of breath; she was constipated and had abdominal cramps. There are a certain number of chronic nephritic patients who are operated upon after such diagnosis as acute appendicitis, intestinal obstruction, gall bladder disease, ulcer of the stomach, etc., and the surgeon finds nothing, and subsequently that patient has chronic nephritis of some sort. In some way the renal disturbance produces a symptomatology in the abdomen and that symptomatology may simulate very strongly some acute abdominal condition, or chronic condition, that is usually treated by the surgeon. If you keep that in mind and get an examination of the patient's urine before operation, and look at the eyegrounds, you may save yourself a certain number of unneeded and undesirable operations. Several times I have seen these patients in whom the eyegrounds gave evidence of vascular disease, and the explanation of the abdominal discomfort probably lay in the combination of some sort of toxins, those from the renal disturbance, plus a generalized vascular condition. The mechanism is obscure, but the point to remember is that renal disturbance of a nephritic type may cause abdominal disturbance that closely simulates surgical disease.

Case 4.—This case illustrates what I have said about the oedema of renal origin clearing up spontaneously. This young gentleman has had oedema present in the face and body. He was cognizant of it on several different occasions, and he was oedematous when he came here. Now he is practically free from oedema. Very likely he has been treated for oedema, but he got rid of it outside of the hospital without any treatment, except that of bootleg liquor, which probably was not very beneficial to his renal condition. He is a consumer of white mule when he can get it; he has consumed a large amount, and whether or not that had anything to do with the etiology of his nephritis, I do not know. This boy is not well of his renal disturbance; he always has albumen present—3 plus, 2 plus, 1 plus, etc.; whether he is oedematous or not, he has albumen. He has no hypertension, no evidence of any circulatory disease; his heart is not enlarged enough to make his circulation, as far as we can judge, responsible for the oedema. It is a type of nephritis with recurring oedema. Later on he may become more oedematous. He may lose his oedema as the result of treatment, and it may never recur. He is not apt to lose the evidence of renal disease and will probably remain a nephritic. What the manifestations will be in the future we cannot say at present, but it is not necessarily the type that progresses to continuous oedema. I have seen these patients do one of two things: they lose the oedema and never develop it again and progress as the interstitial type of kidney lesion over a long period of time; or I have seen just the opposite,

a small amount of oedema become continuous and finally marked. The point I want to illustrate is that oedema comes and goes spontaneously in many of these cases. There are changes taking place, but we do not know what they are.

Question: When you follow the method you are advocating do you ever return to the use of cathartics?

Dr. Christian: Yes, I use anything that anyone else has found efficacious in treating this condition before I give up the fight.

Question: To what extent are you governed by the heart rate in giving digitalis?

Dr. Christian: I probably said that I did not give it below 35. But I am not afraid of producing heart block with reasonable therapeutic doses; a moderate degree of heart block does not do any harm. Even in heart block I use it on the basis of its effect upon the heart muscle, and usually it can be used with safety. If the heart is enlarged and the patient oedematous, when the pulse is normal or even slow, I use digitalis and very often obtain very satisfactory therapeutic results.

ADDRESS ON OBSTETRICS*

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OMAHA, NEBRASKA

From the earliest time in the history of the world, supernatural powers have been credited with exercising a controlling influence over child-birth; some to aid, some to hinder, all to be reckoned with in matters pertaining to the welfare of the mother and child. The means employed to propitiate the gods and to combat the demons were indeed grotesque and ingenious. There were accoucheurs among the gods, and thus we mark the beginning of specialism in medicine.

It is worthy of note that in the spiritual life of nations, the god, or as is almost invariably the rule, the goddess, who overrules and directs the delivery of the mother, is the same goddess who reveals herself in the conception of the child life.

The introduction of monotheism has not been altogether successful in disposing of the goddess Astarte and her innumerable aliases of many ages and nations. From the synagogue of the Jews men were called in to pray with loud voices for deliverance of the patient from the evil spirits; while the Persians shouted their prayers from the housetops and in the temples.

In difficult cases in which the mother is made to realize her dependence, it is but natural that she should find encouragement and comfort in the hope that she may be ministered to in some supernatural way. We find the expression of this in the influence of gods, evil spirits and demons, and in the sympathetic and allegorical actions performed in the presence of the patient. The helping power of the gods was sought through the intercession of priests or by direct prayer; again by the offering of sacrifices or the honest confession of patient or husband. In dealing with the evil spirits, sacrifices are rendered, amulets are worn, weird sayings are oft repeated, but more effectual than all these was the closing of the doors against the demons. They were frightened away by crying and shouting, and decoyed away to other homes by the considerate husband. In order that there shall be no obstruction to the passage of the child and that it may be born without delay, the doors of the dwellings were opened, lids were removed from vessels and everything about the dwelling was left open and exposed.

By way of example and instruction to the unborn child, the mother was enjoined to creep along narrow passageways; neighbor women entered the room crying and lashing themselves in their strenuous efforts to neutralize the pains of the mother.

The means of delivery were varied and amusing; there was the jingling of silver coin in the hope of encouraging the child to greater activity in its progress to the outer world. The father came close to the mother and then quickly receded, in the hope that the child would follow him. Such practices were common to all nations, however, far separated. Belief in demons has existed in relation to obstetrics from the earliest time. Danger, fear and distress foster these beliefs and the evil spirits are held accountable for all calamities of life.

And so throughout the civilized as well as the uncivilized world, means are employed for appeasing and banishing the evil spirits. There were verses to recite, amulets to be worn, and weapons to display. In East India, the pregnant woman must not appear on the street with her hair down, lest the evil spirits become entangled in her tresses. The gypsy carries an open knife, and the shoulder blade of a donkey, on which the blood of a child is sprinkled in the last quarter of the moon; this suspended by the hair of a donkey's tail. The yawning Austrian quickly covers her mouth with her hand, lest the evil spirit enter and possess her person. The woman of Algeria carries the ashes of the acorn mixed with oil, and the Mohammedan a verse of the Koran. The Japanese refuse to sit beside running water, for there abide the evil spirits, and the Russians frequently change their shoes to mislead the pursuing demons.

"It would be difficult for one who has studied modern obstetrics to realize that obstetrics had no place in science until William Hunter in 1774 published the results of his observations on the 'Anatomy of the Gravid Uterus.' Thus was laid the foundation which has made possible the development of obstetrical knowledge in the past century to outstrip that of the preceding ten centuries.

*Presented at the opening of the Wm. H. Coleman Hospital for Women of Indiana before the Indiana University School of Medicine, Indianapolis.

"We appreciate how difficult and uncertain must have been the diagnosis of gestation in obscure cases, when there was no knowledge of the physiological changes which gestation effects in the cervix, when auscultation of the foetal heart and the uterine souffle were unknown, when ballatement and the intermittent contractions of the gravid uterus had never been pointed out."

The pathology of pregnancy and the puerperium were enveloped in mystery. With no knowledge of surgical cleanliness and with technique of the crudest sort, the hazard of a Caesarian section must indeed have been appalling, though surely the indications were at times recognized. With no means of accurately measuring the pelvis, pregnancy was allowed to progress to the point of certain disaster to child and mother. The relation of the diseases of the kidney, the lungs and the heart to pregnancy were little understood, and the condition was allowed to proceed, unmindful of the dangers until they were confronted by them, and then only to realize their utter helplessness.

We grant that prayers to their gods, the wearing of amulets and the intercession of priests and friends may have served a good purpose in giving encouragement to the mother, but we shudder to think of the awful fate of the woman left to her vagaries without the assistance of one who knows so much as the anatomy and physiology of the organs of reproduction, much less the mechanism and pathology of labor; who knows nothing of the premonitory signs of puerperal convulsions; how to prevent, much less to treat puerperal sepsis; who is unequal to the demands of placenta previa, and fails to recognize the existence of ectopic gestation.

Who of us would not shrink from the responsibility of an obstetric case, watching for hours at the bedside of a woman suffering agony beyond that of most surgical operations, if the new science of obstetrics were a closed chapter. Conceive, if you can, of the help of one ignorant in great measure of the anatomy and physiology of the organs involved in the phenomena that he is to watch and assist to a safe termination. Knowing nothing of the mechanism by which the process is normally performed, with nothing at his command to overcome dystocia, powerless to relieve agony by an anesthetic, ignorant of the means of prevention and cure of the accidents of labor, unconscious of the existence of puerperal sepsis, embolism and thrombosis, he may be compared to a mariner tossed upon the sea without chart or compass, even as one who knows not his ship.

The history of obstetrics is the history of civilization. Obstetrics is the oldest branch of medicine. It found its origin in superstition, the relic of which is found to this day in patent medicines and nostrums. The haggard old witch and grey-bearded magician are the prototypes of the patent medicine vender of the twentieth century. "And who can tell but that in a hundred years from now, some of our most cherished views may not be looked upon as superstitious?"—(*Gellhorn*).

In this century and in the two preceding centuries obstetrics has been placed upon a scientific basis, but to designate obstetrics as a science would be taking unjustfied liberties. Even yet it is more of an art than a science so much is there to be done before we can write the word *finis* at the end of the chapter.

Permit me to present a few of the makers of modern obstetrics. First of all there was the famous Chamberlain family with their "iron tongs" which they held within the family circle as a secret for two hundred years.

The first obstetrical forceps was invented probably in 1580 by Peter Chamberlain, the eldest son of a Huguenot, William Chamberlain, who fled from Paris in 1569 and settled in Southampton. In 1670, Hugh, one of the large family, went to Paris and tried to sell the instrument for $7500. Mauriceau, to test the value of Chamberlain's pretenses, suggested that the latter attempt the delivery of a woman with extreme contraction of the pelvis, upon whom he had decided to perform a Caesarian section. Chamberlain claimed that nothing could be easier, and at once, in a private room, set about the task. After three hours of vain effort he was obliged to acknowledge his defeat. The woman died from injuries to the uterus; the negotiations for the sale were dropped, and Chamberlain returned to England with his secret unrevealed. Later after wrecking a bank, he fled to Holland where he sold the secret to a doctor named Roonhuysen, in Amsterdam, who sold it in turn to any doctor having the necessary large amount of money, but sold only half the forceps, thereby adding fraud to infamy . . . The original forceps of the Chamberlains was found in 1815 in a hidden closet in a house in Essex, England, occupied by several generations of the family."—(*DeLee*).

Since the time of the Chamberlains innumerable modifications of the forceps have appeared. The only radical changes have been the addition of axis traction designed by S. Tarnier (1828-1892) of Paris.

In the nineteenth century, gynecology made rapid strides. A number of factors contributed to this advancement. Women were no longer attended in child-birth exclusively by midwives, nor was the obstetrician compelled to conduct the delivery under cover of a cloth as in former periods. This allowed for more thorough study. Furthermore, all other branches of medicine received a powerful stimulus. Improvements in the microscope led to hitherto impossible investigations into the structure of the body. In 1835, Schleiden, of Germany, showed that the organism

of plants was composed of units, called cells. In 1838, Schwann proved the same to be true in animal bodies, and the work finally culminated in 1850, in the cellular pathology of Rudolf Virchow of Berlin.

Scientific Obstetrics, as it is called today, began in the early part of the eighteenth century, when Sir William Hunter revealed the anatomy of the pregnant uterus. He did more than that for it was he who ended the rule of the midwife and opened the way for the medical profession in the management of maternity cases.

The discovery of ether and chloroform and first employment for surgical purposes in 1846 was epoch-making. Coupled with McDowell's success in invading the abdominal cavity, it marks the beginning of the modern era of surgery and obstetrics. The first to avail himself of the constellation was Sir James Young Simpson in Edinburgh (1811-1870) who may well be regarded as the father of our specialty. Not only did he extend and perfect gynecologic operations, he also used the new anesthetics in obstetrical work. He was bitterly opposed at first by physicians and theologians, but after he had delivered, in 1853, Queen Victoria of her eldest son, the Prince of Wales, later King Edward, the method of rendering child-birth less painful became legitimate and popular. From this period dates the following anecdote: One morning the students coming to the lecture room, found the door closed and bearing the notice:—"Dr. Simpson will not meet his class as he has gone to London to deliver the Queen," whereupon a wag wrote underneath, "God save the Queen."

No single man in the history of medicine has made such priceless contributions to medicine as did Pasteur. He paved the way for Lister who applied the principles of Pasteur to surgery. The mortality of major surgical operations up to this time was appalling, ranging from fifty to ninety per cent of all major cases. Lister operated in a carbolic acid spray and saturated his dressings and ligatures in a solution of carbolic acid—this to destroy the germs that Pasteur had discovered as a cause of wound infections. And from this time to the present, surgery has become increasingly safe in the hands of the surgeon. When Lister died England mourned the loss of her greatest surgeon. His work was done at the time of our Civil War when thousands of our boys in blue and grey lost their lives from gangrene and erysipelas which would not have occurred had the work of Pasteur and Lister been known.

But it was not alone in surgery and the epidemic diseases that the toll of life and suffering were taken as the result of the invasion of microorganisms. In the maternities of Europe and America the death rate from infection acquired in child-bearing was appalling. One mother in ten lost her life, and fortunate indeed was the mother who passed through her travail unscathed. Oliver Wendell Holmes, then an anatomist in Harvard University, though best known to us as a man of letters, knew nothing of germs, for Pasteur had not yet revealed the secrets of that hidden life, yet he proclaimed his theory of the contageousness of child-bed fever and fearlessly laid the responsibility of its spread upon the medical profession. Of course, he was bitterly arraigned and of these attacks made upon him by his colleagues he writes:—"When, by the permission of Providence, I held up to the professional public the damnable facts connected with the conveyance of poison from one young mother's chamber to another's—for doing which humble office I desire to be thankful that I have lived, though nothing else shall ever come to life—I had to bear the sneers of those whose position I had assailed, and, as I believe have at last demolished, so that nothing but the ghosts of dead women stir among the ruins." "The pestilence carrier of the lying-in chamber must look to God for pardon, for man will never forgive him."

And at about the same time Emil Semilweis, an assistant in a hospital in Vienna, was proclaiming a similar theory and for his pains he was driven by the profession to the mad house. By the introduction of simple rules governing the conduct of doctors in the care of the expectant mother the mortality dropped from near eleven per cent to less than three per cent, and since the day of Holmes and Semilweis the mortality has steadily declined till now it is not more than .2 of one per cent.

At this time special maternity divisions existed in various cities. The oldest was in the Hotel Dieu in Paris about the year 1660. Vienna followed some time later; then came London, Edinburgh, and Manchester; still later, Berlin and Dublin. In most instances, these divisions formed part of the general hospitals and were, from time to time, devastated by epidemics of puerperal fever. The conditions in all these hospitals were beyond belief. Lawson Tait described the Edinburgh Infirmary as he saw it in 1860. Said he, "It was a four-storied building, badly lighted, very badly ventilated, crowded with students for many hours of the day, with a very insufficient number of nurses who were void of training; the wards stunk; they were over-crowded and marked by numerous faults in cleanliness and hygiene which would not be tolerated now in the oldest-fashioned institution in the country.

"The operating table was of wood and of fabulous age. It was sometimes thought necessary to have a new mattress for the table when the stuffing was found matted together in lumps by the blood which had during many years soaked through its covering. The only correct garb for the surgeon was a frock-coat (the oldest and shabbiest in his wardrobe) which was kept in the

surgeon's room and never renewed or cleaned during his twenty years of operating work.

"The operating theatre attendant was permitted to employ his spare time in the post-mortem room; the surgeons came straight from the dissecting room to operate, after simply washing their hands. Ligatures were used which had already been soiled by handling with blood-stained fingers, to bind up wounds in a second case. And at Edinburgh these ligatures were always worn ostentatiously by the House Surgeon, like a badge of knighthood, in the button hole of a coat which often rivaled that of his chief in dirt."

With such a state of affairs, the slightest injury, the smallest operation was fraught with danger, and Valpeau, of France, said of this period; "A pin prick is a door open to death."

If such conditions prevailed in 1860, how must they have been one hundred years before. It was, therefore, an inspired attainment of Charles White in 1773 to have concluded that foul air and surroundings, filthy bedding, as well as the retention of the lochia and the excreta are the primary causes of puerperal sepsis and to have banished the dreaded "putrid fever" from his lying-in ward by strict cleanliness and general hygienic measures which were as revolutionary in his day as they are self-understood with us.

You will recall that when Paul was brought by the centurian before the Chief Captain claiming immunity from the scourage because of the fact that he was a Roman citizen, the Chief Captain answered him—"With a great price obtained I this freedom." And Paul replied, "But I was free born." The profession of medicine and nursing have obtained their freedom with a great price. Enslaved by ignorance, superstition and bigotry doctors and nurses struggled in the past against odds we know not of. The shackles were loosened by Pasteur and Lister, Holmes and Semilweis, Morton and Simpson and last but not least—Florence Nightingale. When Florence Nightingale took charge of the hospitals in the Crimean war the mortality was fully fifty per cent and the sanitary conditions were unspeakable. Free born into a professional life with science wedded to the art of practice, we are indeed fortunate.

Through the generosity of Mr. and Mrs. William H. Coleman you have erected and equipped a maternity hospital that is destined to be of priceless value to your community and to the state. Less than a score of years ago, Doctor Whitbridge Williams, Professor of Obstetrics in Johns Hopkins University, made the statement that there were but two adequately equipped maternities in the United States and that his was not one of them. Today there are not more than a dozen such institutions.

The Indiana University is fortunate indeed, and the donor of this priceless gift is not only deserving of your everlasting gratitude, but as well of commendation for his wisdom in the choice of his bequest.

And we ask:—"What may we expect from this institution? What accounting should the management make to the donors in the years to come?" I assume that its purpose is two-fold—first, to provide the best possible service for maternity cases and, second, to serve in an educational capacity.

That you will provide the best possible service for maternity cases there can be no reasonable doubt. You have erected a structure that conforms to all the specifications of modern, maternity hospital construction; the equipment is all that could be desired; you have the assurance of perpetuity and generous support from your state under the direction of the authorities of the State University and your doctors and the training school for nurses will see to it that the patients receive skillful and sympathetic attention. Of all this we may be assured.

And how can this institution serve in an educational capacity? Were it to fail in this regard, it would have no place in your state university. Let us first enquire into the needs for educational facilities in the field of obstetrics. We have alluded to the distressing conditions that prevailed in the maternities of the world in the days preceding the advent of antisepsis. They existed because of lack of knowledge on the part of the medical and nursing professions. In those days nurses and doctors ministered to the plague stricken multitude, but knew not that their garments bore death. Then science revealed the germ that festers the wound and taught how it could be killed that the wound may heal true and clean, how the water source may be preserved pure and the dwelling made clean, sweet and wholesome. Science tracked the plague poison to its lair and staid its course.

"But science alone will not fulfill the purpose of your institution. Science must be wedded to the spirit of service and self-sacrifice; head and hand must reinforce and direct the heart in order that the service of doctors and nurses shall be something more than kindly ignorance, for without knowledge and skill no love, no sympathy, no tenderness, no gentleness will save the sick; for if science guides not pity, harm may come to those we seek to aid." Knowledge and skill you possess and happily you are equally assured that this maternity will reach out into the field of social service under the leadership of your Dean, who is recognized the country over for the splendid pioneer work he has done in the social service of our medical institutions.

The work done within the walls of this building will not suffice. Doctors, students and nurses will extend their activities to the poor of your city. In their visitations and in the dispensary they will observe and instruct the expectant mothers

and in so doing will more than halve the casualties of obstetrics and early infancy. Lives will be saved, mothers will be spared a life of invalidism and the babies will be given a fair start in life.

The need for educational facilities for students and nurses is pressed upon us when we recall that puerperal infection and eclampsia account for full half the mortality in obstetrics and that these two diseases seldom arise in well-ordered maternities. This is indeed a serious indictment against the private practice of obstetrics. It is so for many reasons, but chiefly because of the lack of thorough training in obstetrics in medical schools and training schools for nurses. Happily there have been great advances of late years in the teaching of obstetrics, but there is need for more. The committee on Maternal Welfare tells us that thirty per cent of the general practice of medicine has to do with obstetrics and that only six per cent of the academic hours in our medical schools are devoted to the teaching of obstetrics. The conclusion is inevitable that more time and larger and better facilities should be provided for the teaching of obstetrics.

But a maternity is not alone concerned with the welfare of the mother. There is the new-born infant to be reckoned with. We are told that the infant mortality in the United States outstrips all other civilized countries save Russia and Poland. What a splendid opportunity will be afforded by this maternity in the care of the newborn of your community and in the instruction of doctors and nurses who go out from this institution.

Without fear of contradiction may it be said that the interests of mother and child are best safeguarded in such institutions as this: that the instruction and training of medical students and nurses here cannot fail to bring about a betterment in the private practice of obstetrics in your state, to the end that you will have a happier and more vigorous citizenship.

In closing permit me to express in words that are all too inadequate how deeply we must regret that Dr. Orange G. Pfaff is not here to rejoice with us in the realization of his life's dream. His spirit in your lives will be an inspiration always; it is here tonight, it will permeate this instituton in the years to come.

You will recall the story of Dr. William MacLure who served the God-fearing folk of Drumtochty for near half a century. How he was at the beck and call of every man, woman and child in that wild straggling district, year in and year out, in the snow and in the heat, in the dark and in the light, without rest and without a holiday for forty years. On a wooden cross at the head of the grave of William MacLure were written these words; words that might well have been written of Dr. Pfaff: "Greater love hath no man than this, that a man lay down his life for a friend." And likewise the eulogy of Lord Killspindie which ended with the prayer, "That all doctors everywhere may share his spirit"—the Spirit of Service and Sacrifice wedded to Science and Skill.

DISPLACEMENT IRRIGATION OF THE NASAL SINUSES WITH SUCTION*

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Displacement irrigation of the nasal sinuses is a new procedure in the conservative treatment of the accessory sinuses of the nose. The subject was presented by Dr. Proetz, of St. Louis, at the meeting of the American Medical Association in 1926. His paper was published in the Archives of Otolaryngology, July, 1926.

When this paper was presented I employed lantern slides to show the method of introducing fluids into the sphenoid and posterior ethmoid sinuses. Here, however, I shall state briefly the Proetz method of procedure. "The patient is placed in the supine position, with his head projecting beyond the top of the treatment chair or table. The occipito-atloid joint is extended until the tip of the chin and the external auditory meatuses are in the same vertical plane. This renders the sphenoid sinus, with its ostium upturned, the most dependent structure in the nasal chamber. A 'V' shaped pocket thus occurs at the junction of the face of the sphenoid with the cribiform plate of the ethmoid." The irrigating fluid is introduced into the nose from a graduated medicine dropper. Sufficient fluid is introduced to submerge the ostia of the posterior sinuses. The fluid does not enter the sinuses because the ostia are too small to permit escape of the air contained in the sinuses. Gentle intermittent suction, not more than three pounds, is applied to one nostril, the other nostril being closed. The pharynx is sealed by having the patient repeat "K-K-K". When the suction is applied an air bubble is withdrawn from the sinus through its up-turned ostium; when this suction is released the air bubble is replaced by a drop of the overlying fluid. Twelve or eighteen alternations or squeezes of the bulb are usually sufficient to fill the sinuses. The patient is then returned to the erect position.

During the past winter I became interested in the displacement treatment and decided to try it out. I first experimented on myself. Then I treated two physicians who co-operated with me in every way. It was soon apparent that we were greatly benefitted. This encouraged me to proceed with the treatment of other cases, and as I became more familiar with the method I tried out some ideas of my own.

As a preliminary treatment of the nasal cavity, before giving the regular displacement irrigation with suction, I often use simple irrigation. To

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cleanse the nose of any free mucus, muco-pus, or dried pus adherent to the mucous membrane. The patient is placed in the Proetz position, and the nasal cavity is filled with warm salt solution; after a minute the patient is asked to sit up, to rid himself of the fluid, simple canula suction will aid. A clean nasal cavity is necessary, otherwise one cannot know whence comes the muco-pus which is obtained in the displacement irrigation with suction.

Before beginning the irrigation of the nasal cavity with suction, it is better to shrink the mucous membrane of the ostia, to render the ostia as patent as possible. After experimenting with several solutions I have found the following ephedrine and cocaine solution very satisfactory:

Ephedrine 3%—Dr. I.
Hypertonic Salt Solution 2%—Dr. II.
Cocaine sol. 1% in Hypertonic Salt. 1%—Dr. III.

This combination makes a one-half per cent solution of ephedrine and cocaine in hypertonic salt. Diluted once or twice it makes ¼ and ⅛ per cent respectively; the latter is the strength I first apply. I instill 1 to 2 c.c. of this diluted solution into the nose and apply the displacement treatment with suction. A few alternations suffice, as it is not necessary to fill the sinuses in order to shrink the mucous membrane of the ostia. So far, no reaction has followed the use of this solution. Lately I have been using ½ to 1 per cent ephedrine solution, without the cocaine, especially in the treatment of subacutes and chronics.

For the intermittent suction in the displacement treatment, I use a Sonderman tube. I find that the Sonderman tube, with an olive-shaped glass nasal tip attached, gives me a certain sense of touch. Dr. Proetz recommends the introduction of a small amount of the irrigating fluid at one time, about 2 c.c., in order that the fluid may not overflow into the pharynx. This amount of warm salt solution is introduced into the nostril with a graduated medicine dropper. Intermittent suction is then applied, ten to fifteen alternations or squeezes of the bulb is sufficient. Then another 2 c.c. is introduced, followed by the alternations of suction. The introduction of the irrigating fluid with the intermittent suction is continued until the sinuses refuse to take up any more of the fluid. The amount of salt solution will vary with the size of the sinuses and the patency of the ostia, an average of 2 to 6 c.c. will fill the cells which are receptive. In the late stages, in acute cases, an overflow of the sinuses is desirable, as pus will tend to come out with the overflow. In some cases more than a dozen alternations are necessary; as many as twenty to thirty are sometimes given.

During the past six weeks I have been trying out a hypertonic salt solution, 2 to 4 per cent, as a nasal wash without suction; and in the displacement irrigation with suction, with beneficial results. The English surgeons, Rose and Carlos, claim that hypertonic salt solution is very beneficial if employed in the early stages of infected wounds. They base their claim on the fact that hypertonic salt solution encourages lymph drainage of the tissues and restores their vascular supply. Also, that it disintegrates any leucocytes with which it comes in contact. They claim that hypertonic salt solution, say 5 per cent, exercises considerable osmotic pressure, so that free fluid is withdrawn from the red cells, which become shrunken and crenated. It is known that the isotonic solution (normal salt) has no osmotic pressure on either side; and that the hypotonic solution (plain water) allows the cells to absorb water to such an extent that they swell. From these facts, it occurred to me, that the hypertonic salt solution if used in the treatment of certain stages of nasal inflammation might be more beneficial than the isotonic. The results have borne out this fact. After flooding a turgescent nasal cavity with a warm hypertonic salt solution (irrigation without suction), and after keeping the patient in the recumbent position for several minutes, I could notice a shrinkage of the mucous membrane. This was true in many acute cases. In some it was quite marked.

Significance of pathology in the treatment of cases: Dr. Joseph Beck says, "Acute rhinitis should be thought of as a rhinosinusitis." If this is true, then the early pathology of acute rhinitis and rhinosinusitis is the same. In describing the pathology of the latter, there are four stages to be considered. First stage—vascular or venous engorgement. Second stage—transudation, or swelling of the mucous membrane and the out-pouring of a watery serous discharge. Third stage—leucocytic infiltration, or outpouring of lymph, the swelling of the mucosa becomes greater and the ostia are completely closed in many of the accessory cavities. Fourth stage—or stage of pus formation. During the earlier stages, that of vascular dilatation, transudation and leucocytic infiltration, namely the first three stages, the displacement irrigation with suction is not to be recommended. In the fourth stage, or stage of pus formation, which succeeds the leucocytic infiltration, there is a marked increase in mucin, giving the muco-purulent or pus-like character to the discharge. The purulent period is the longest in duration of the whole period of acute inflammation. It is during this period that I recommend the displacement irrigation of the sinuses with suction.

After the acute rhinosinusitis clears up, there is often a predisposition to further attacks because of latent infection in the sinuses. I consider many of these attacks that occur over an indefinite period as acute recurrent attacks and not as subacute or chronic paranasal sinus disease. It was the opin-

ion of Dr. Beck, in his Applied Pathology, 1923, that a sinus once affected by an infective process would never undergo a complete resolution. From present results I am inclined to believe that displacement irrigation with suction will bring about complete resolution in some cases.

The pathology of acute cases applies to the exacerbations of some of the subacute and chronic paranasal sinus diseases. In the subacute and chronic cases it is necessary to shrink the mucous membrane with astringents to render the ostia patent, then most of these cases will respond to the displacement irrigation with suction.

If the cases do not respond to treatment, it means that a more extensive pathology exists, such as polypi, polypoid degeneration, osteitis, or a marked round cell infiltration in the subepithelial layer of the mucous membrane. In some of the cases conservative intranasal surgery, such as removal of polypi, removal of hypertrophied and polypoid middle turbinates, straightening deflected septums, and irrigation of antri, will prepare the subacute and chronic cases for displacement irrigation with suction. I consider clean, non-infected antri essential to success in the displacement treatment. For this reason the antri are studied most carefully, and if the symptoms indicate infection they are irrigated before displacement treatment is commenced.

Antiseptic solutions in the nose: Antiseptic solutions should not be instilled into the nasal cavity until four to twenty-four hours after the displacement irrigation, because the salt solution remains in situ for an indefinite period; several hours to several days, depending upon the motility of the cilia, patency of the ostia, size of the cells, and the amount of physical exercise the patient takes. It has been noticed that during a game of golf most of the irrigating fluid comes away the first few hours; this probably is due to stooping and deep respiration. The antiseptics I have used are collene 25 to 50 per cent, neo-silvol 10 to 15 per cent metaphen or mercurophen 1 to 5,000 in acute cases. In the subacute and chronic cases I use metaphen, or mercurophen 1 to 5,000, and Arbuckle's solution of mercurochrome 1/3 per cent in glycerine and alcohol. The mercurochrome solution seems to be more painful than the other solutions mentioned, so I have discontinued its use. I believe any solution that is irritating to the nasal mucous membrane should not be used. These solutions are instilled into the nose 1 to 2 c.c. at a time, and suction is applied just as in displacement irrigation. Metaphen, mercurophen and neo-silvol have proved to be the most satisfactory agents. Whether they are superior to others as nasal antiseptics I am not ready to state, as there remains much to be done in the way of investigating the behavior of antiseptics instilled into the nose. I am of the opinion, however, that solutions instilled into the nose, even in the recumbent position, without suction being applied, never enter the accessory cavities through the normal ostia, and by this I mean ostia which have not been altered by surgery. In displacement irrigation with suction the solutions do actually enter and remain for some time in the accessory cavities. This has been demonstrated frequently. For instance, two days after using Arbuckle's solution, the nasal cavity was cleansed thoroughly and the displacement irrigation with suction given, and a stained solution was obtained in the overflow. In fact, in several instances, a red-stained muco-purulent cast was washed out two or three days later. In other cases, where argyrol was used, a brown-stained muco-purulent secretion appeared in the washings. It was interesting to note in the washings actual casts of the sinus cells, of various shapes and sizes, some round, some oblong, some the figure eight or dumb-bell shaped.

I dispense with the saline irrigation with suction when the washings show a marked clearing up of shreds and pus. In such cases, after cleansing the nasal cavity with a wash and canula suction, I use an astringent, such as ephedrine and cocaine, with suction, then I instill neo-silvol, metaphen, or mercurophen 1 to 5,000 and apply intermittent suction. This treatment is given every three or four days. After several such treatments it is necessary to test out the sinuses with the displacement irrigation, with saline solution, to see if they are free from muco-pus. If pus is present, a few more displacement irrigations may be necessary before using the nasal antiseptic again. I find it convenient to put the returned irrigating fluid in a conical glass container, so as to compare the washings with clear water that has been put in a similar container.

The cases treated with displacement irrigation were: Acute colds, with mild sinus involvement, catarrhal inflammation, acute, subacute and chronic ethmoiditis, sphenoiditis, and pansinusitis. Some of the cases of ethmoiditis were complicated with acute and subacute frontal sinus disease and antrum disease.

Claims for the displacement treatment are: 1. A mechanical cleansing. 2. A thinning of the viscous exudate—loosening the secretion from the sinus walls and rendering it removable by suction —thus mitigating its irritating action. 3. Better diagnostic possibilities — radiograms are made clearer and more definite with iodized oil introduced into the posterior ethmoid and sphenoid cells.

Results of the displacement treatment: Most of the acute cases, which include the recurrent, were relieved sooner than when the usual treatment with sprays, nasal packing, etc., was used. Displacement tests made on some of the patients several weeks later did not show confined or retained pus. However, in two cases in which the patients

claimed that they felt perfectly well, the displacement tests showed shreds and pus in the irrigating fluid. Most of the subacutes and chronics experienced greater relief from the displacement treatment than from any other method of procedure.

Considerable relief was afforded that group of patients classed as "catarrhal inflammation" cases; the commonest condition and least recognized of all the diseases of the accessory sinuses, according to Skillern, because the cases present few classical symptoms of sisus disease. In these cases the post nasal discharge, and the persistent pharyngitis sicca, (fulness and dryness of the naso-pharynx) keep up a constant irritation which causes the disagreeable morning hawk and rasp. The displacement irrigation renders the post nasal discharge more fluid in consistency, so that the discharge is easier to get rid of; and the dry glazed mucous membrane is rendered moist and pliable, due to the gradual emptying of the posterior cells. Typical headaches due to diseases of the accessory nasal sinuses have been relieved by



displacement irrigation in a number of patients. In some the relief continued one to several days, and in some cases the head pains grew gradually less as the treatments continued. Severe neuralgia over the orbital region in several instances was relieved almost immediately by the displacement treatment, with .2 c.c. ephedrine and cocaine solution.

Complications following the displacement irrigation with suction: There were two cases of fullness in the ears, with temporary impairment of hearing; in one the condition lasted a few minutes, and in the other it continued for several hours. There was one case of ear ache, caused by a fit of coughing and clearing of the throat when an overflow passed into the pharynx; in this case there was probably too much pressure used with the suction bulb; after several hours the ear ache subsided. The patient was treated subsequently with displacement irrigation and no disturbance followed. There were several cases of sneezing, coryza, and moderate frontal and eye pain after the use of some of the antiseptics, especially Arbuckle's solution; but these symptoms disappeared after several hours. In a unilateral sinusitis there is a possibility of carrying the infection into the other nasal cavity, as a result of using an excess of fluid or too much pressure; this happened to one of my patients, but caused only a rhinitis which cleared up in a few days. I believe one can train one's sense of touch so that a light gentle compression will give the desired results.

Diagnostic possibilities: Radiograms of the posterior sinuses, after displacement treatment with iodized oil, (lipiodol diluted one-half with olive oil) show the cells clearly outlined. Those sinuses with marked pathology and the hyperplastic type will not fill. I recommend a trial of the displacement treatment with oil, as a procedure that may be of some aid in the diagnosis of suspected sinus disease where the usual radiograms or clinical symptoms have failed to make a definite diagnosis.

It may come about in the future that nasal hygiene will be observed by rhinologists as a regular procedure in cases of rhinosinusitis during the latent or quiescent period; just as dental and oral hygiene is carefully observed by dentists. To carry out the nasal hygiene treatment, I suggest that the rhinologists give the displacement irrigation with suction a trial. I believe that timely used in the acute and recurrent cases, and followed by nasal antiseptics, it will in a number of cases prevent the subacute and chronic nasal sinus diseases from developing. Even many of the latter have been benefitted materially but it is too soon to claim any cures.

ONE HUNDRED CONSECUTIVE HERNIOPLASTIES WITH END RESULTS*

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The resort to surgical treatment for the cure of disease or disability can be justified on no other grounds than the success of end results accomplished by such treatment.

It is therefore advisable that at every opportunity a check should be made upon end results of surgical procedures in definite groups of cases, to the end that the profession may be intelligently advised as to their value. Furthermore, the critical study of the cause of failure, if failure occurs, may result in the future avoidance of error.

The critical study of end results in surgical therapeutics has been greatly neglected, if one is to judge by the scarcity of medical literature devoted to that study. However, in recent years there is unquestionably a movement that is gradually gaining momentum in this direction. Under the stimulus of Social Service departments the

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American College of Surgeons and the American Hospital Association, the clinical records of hospitalized patients are showing great improvement and are being extended to show follow-up notes, recording the end results obtained by the patient.

The reason for the lack of accurate information concerning end results in series of cases of any considerable number, is not hard to understand. For an intelligent estimate of end results, two things are fundamental: First—accurate clinical and laboratory records covering the facts pertinent to the patients illness and progress while in the hospital. Second—an organization trained and equipped for the purpose of obtaining information of the patient's condition subsequent to his illness. Just how many of our hospitals possess clinical and laboratory records, the study of which would afford an adequate basis for an intelligent end result estimation, is an interesting question.

It is obvious, I think, that insofar as a record fails to show every pertinent fact relative to the diagnosis and treatment of the patient, just so far does it fail to be of value in the proper estimation of end results. As for the second consideration, a trained organization, I am sure very few hospitals in our state are equipped. It appears that the resources of our hospitals are so completely absorbed in the daily task of caring for the sick, that no provision is available for the accumulation of facts covering the one fundamental excuse for their existence—how much good are they doing.

If, in the early stages of hospital development, some genius with a turn for the practical, had established the necessity that every hospital must be equipped with the necessary means to inform itself of the end results of treatment, great benefit would have resulted in methods of treatment.

For some reason rather hard to explain, there exists a prejudice against the surgical treatment of hernia. This prejudice is not wholly confined to the public but is to some extent entertained by the profession itself. The public is undoubtedly influenced by advertising quacks, whose principal objective is to discredit surgery. Any prejudice existing in the medical profession must be due to a failure to inform itself of the dangers of hernia and the excellent results of surgical treatment afforded by modern methods.

Obviously no conclusions can be drawn from so small a series as one hundred cases, yet it is reassuring to those seeking accurate information, to know that in this series there were ninety-six cured, with four recurrences, no deaths and no serious complication.

Four per cent recurrences compares favorably with statistics submitted from other clinics, and I believe represent a fair estimate of the radical cure of inguinal hernia by modern surgical methods.

The following tables are submitted for a better understanding of the data contained in a study of the series; which were operated upon by the attending staff of the University Hospital.

AGE GROUP OF TEN YEARS

Up to 10 years.
6 Herniotomies done. 1 bilateral.
No recurrences, no impairment.

10 to 20 years.
14 Herniotomies done. 1 bilateral. 1 incarcerated.
1 sliding.
2 recurrences, no impairments.

20 to 30 years.
22 Herniotomies done. 1 direct. 4 bilateral.
1 incarcerated. 1 hernia with appendix in the sac. 1 deceased, subsequent to dismissal.
1 impaired, no recurrences.

30 to 40 years.
10 Herniotomies done. 1 direct. 1 bilateral.
1 impairment (upon 12th day) no recurrence.

40 to 50 years.
15 Herniotomies done. 1 direct and indirect, two sacs joining at external ring with deep epigastric artery between them. 2 bilateral.
1 bilateral and sliding.
1 recurrence, no impairment.

50 to 60 years.
15 Herniotomies done.
1 recurrence. No impairment. 1 deceased, subsequent to dismissal.

60 to 70 years.
14 Herniotomies done.
1 bilateral. 2 scrotal with varicocele.
No impairment. No recurrences. 2 deceased, subsequent to dismissal.

70 to 80 years.
3 Herniotomies done.
No recurrences. No impairment. 1 deceased, subsequent to dismissal.

RESULTS

Operations		Recurrences	Impairment
Hew Halstead	33	1	1
Mod. Halstead	13	1	1
Andrews	25		1
Ferguson	1		
Ferguson-Andrews	18		
Ferguson-Halstead	3		
Bassini	7	2	
Total	100	4	3

Anaesthetic		Recurrences	Impairment
Ether	72	3	2
Local ½% Novocaine with adrenalin	25	1	1
Local and ether	3		
Total	100	4	3

Preparations		Recurrences	Impairment
(Ether, Iodine Tr. 50%, Alcohol) Ether, Iodine, Alcohol	54	2	3
Wet	37	2	
Merchrochrome	1		

Not given	8		
Total	100	4	3

Suture for Sac		Recurrences	Impairment
Silk	45	2	2
Linen	10	--	1
C. C. G. No. 1	8	1	
Pl. C. G. No. 1	18	1	
Pl. C. G. No. 2	5		
Not Given	14		
Total	100	4	3

Suture for Muscle Layer		Recurrences	Impairment
C. C. G. No. 2	42	2	2
Silk	14		
Linen	7		
Silk and living suture	3		
C. C. G. No. 2 and linen at both rings	9	1	1
C. C. G. No. 1	11	1	
C. C. G. and silk at rings	3		
Double C. C. G. No. 1	3		
S. W. G. Stay sutures and drains	3		
Not Given	5		
Total	100	4	3

The following comments upon the series may be made:

AGE GROUPS

There were eight decades represented in the series, the largest number occurring in the third decade, or the group 20 to 30 years. Two recurrences occurred in the second decade, one in the fifth and one in the sixth.

In the second decade where two recurrences occurred, there were fourteen hernioplasties. In this group there was one bilateral hernia; one incarcerated and one sliding hernia. In this connection it is interesting to note that in three of the groups where recurrences occurred, one or more of the cases were bilateral herniae. There was likewise a sliding henia in two groups where recurrences occurred.

There appears to be no especial difference in end results between the various age groups; the eighth decade comparing favorably with all others. This is reassuring to those of advanced years who find it necessary to submit to operation.

TECHNIQUE

Any student of the operation of hernioplasty is immediately impressed, and probably confused with the multitude of variations introduced into the technique of this comparatively simple operation. Undoubtedly these innumerable variations are inspired by the belief that some fatal error in the technique of the operation is responsible for the recurrences. Within certain limits this assumption is true, but there is strong reason to believe that other factors than the particular type of operation performed, account for many recurrences. The type of hernia, whether direct or indirect, sliding, bilateral, the constitutional characteristics of the patient, complications such as infection, pneumonia, bronchial irritation resulting in excessive coughing, too early release from bed, not long enough period before returning to active labor, account for far more recurrences than error in technique, providing always, of course, the fundamental principles are strictly observed in the performance of the operation.

Seven distinct variations in technique are recorded in the performance of the one hundred hernioplasties, each bearing the name of the surgeon having proposed the method. It is not the intention to discuss critically these various methods, as a description of them may be found in any good book on general surgery.

The object of all these various methods is to build a solid butress at the hiatus in the abdominal parities that will prevent the recurrence of hernia. The main point of distinction in the modern operation is whether this butress shall be made by suturing the muscle layer composed of the transversalis and internal oblique muscle and conjoined tendon to the inguinal ligament, or whether the aponeurotic portion of the external oblique should be the structure joined to the inguinal ligament by suture, with imbrication of the external flap of aponeurosis across the suture line.

The number of cases is entirely too limited to draw any conclusions, and attention is simply called to the fact that the Andrews method of suturing aponeurosis to ligament gives forty-three cases without recurrences, while the Bassini method with seven cases has two recurrences. As mentioned above, recurrences may be caused by factors entirely foreign to the technique used.

A word may be said relative to the suture material used in closing the hiatus. The record shows the use of both absorbable and non-absorbable material. Fifty-six of the former, with three recurrences and twenty-four of the latter with no recurrences. There were twenty where both were used with one recurrence.

It is evident that good results may be obtained by the use of all the above methods.

TREATMENT OF THE SAC

The treatment of the sac, all authorities agree, is a vital step in a successful operation. Its importance lies not in the kind of material used in ligation, nor the disposition of the stump, but in a high ligation so that when viewed from the abdominal side there appears no funnel-shaped depression to court disaster.

In view of the fact that the generally accepted causes of hernia places great emphasis on the failure of the processes vaginalis to completely close at the internal ring, leaving a peritoneal pouch at this point, the complete obliteration of the sac by high ligation appears to have a rational basis.

ANAESTHESIA

A word may be said relative to anaesthesia. One-fourth of the cases were done under local infiltration anaesthesia, with the same proportion of recurrences in the two groups. Regardless of its influence on recurrence, I think it can be safely

said that local infiltration anaesthesia should be the method of choice in most uncomplicated hernioplasties. This operation lends itself admirably to this type of anaesthesia, and the post operative convalescence is smoother than in general anaesthesia.

CONCLUSIONS

Ninety-six per cent cures. Four per cent recurrences.

Controllable factors in recurrences are longer period in bed, abstinence from heavy manual labor over longer period, control of coughing during convalescence, primary wound healing.

CONVERGENT STRABISMUS

CASE REPORT

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The following case of strabismus is of more than passing interest as it illustrates what can be accomplished by careful refraction and early operation when the corrective glasses do not entirely accomplish the desired results.



Figure 1.—Patient before operation and use of corrective lenses, age fifteen years.

T. H., a boy fifteen years of age, attending junior high school, consulted us August 29, 1921, for convergent strabismus and marked diminution in vision, which he had had for some years and for which he was wearing glasses without apparent relief. He had consulted a number of oculists from his eighth to his thirteenth years with numerous changes in glasses. The last glasses given him, presumably under a cycloplegic, were minus 0.50 diopter cylinder, axis 180 degrees, in each eye.

On examination an alternating concomitant convergent strabismus more pronounced in the left eye was observed. Lateral nystagmus was also present. Vision without lenses, in right eye was 20/50 minus one letter, in left eye 20/200, and not improved by the glasses worn.

Under homatropine cycloplegia his refractive error was found to be: right eye, plus 0.50 diopter sphere combined with plus 1.50 diopter cylinder, axis 90 degrees, giving vision of 20/50 minus one letter; left eye, plus 2.50 diopter cylinder, axis 90 degrees, giving vision of 20/65.

Two days later, post cycloplegic examination with corrections of right eye, plus 1.50 diopter cylinder, axis 90 degrees, and left eye, plus 2.50 diopter cylinder, axis 90 degrees, gave the same amount of vision.



Figure 2.—Patient at present time, age twenty-one years.

At the end of three weeks although the boy could see better, the eyes did not straighten, so it was decided to operate.

September 19, 1921—A partial tenotomy of the internal rectus with a tucking of the external rectus was done on the left eye and a similar operation on the right eye, ten days later.

November 26, 1921—A second refraction under atropine was done with the same result as before so that the lenses were not changed. At this time vision with both eyes open with correcting lenses was 20/40 minus one letter with no nystagmus.

This boy finished high school, went to college, was graduated in law and has been admitted to the bar. During these years he has been seen occasionally, and his lenses checked, but not changed.

October 17, 1927—He presented himself feeling he needed a change of lenses. Vision without glasses was, right eye 20/50, left eye 20/65; with his old glasses both eyes open 20/20 minus one letter. Under homatropine cycloplegia his refractive error was found to be: right eye, plus 0.75 diopter sphere with plus 1.50 diopter cylinder, axis 90 degrees; left eye, plus 0.75 diopter sphere with plus 2.00 diopter cylinder, axis 90 degrees, yielding right eye vision of 20/40 and left eye vision of 20/24, and both eyes together 20/20 minus one letter.

After post cycloplegia two days later the following lenses were prescribed: right eye plus 0.37 sphere with plus 1.50 diopter cylinder, axis 90 degrees, vision 20/40; left eye plus 0.37 sphere with plus 2.00 diopter cylinder, axis 90

degrees, vision 20/24. The vision of both eyes together was 20/20 minus one letter.

With both eyes open and the correcting lenses worn the nystagmus disappears; but with one eye open and the correcting lens worn and the other eye covered, the nystagmus remains.

In conclusion, the results accomplished are: Control of nystagmus by full correction of his refractive error; increase of binocular vision with glasses from 20/40 minus one letter in 1921 to 20/20 minus one letter in 1927; increase in vision with correcting lens of right eye from 20/50 to 20/40; increase of vision with correction in left eye from 20/65 to 20/24, and a complete correction of the deformity as shown by the reproduced photographs, one before operation at fifteen years of age and the other at twenty-one years of age.

CONSTIPATION

Russell S. Boles, Philadelphia, (*Journal A.M.A.*, November 19, 1927), emphasizes what appears to him must eventually become the modern conception of constipation; namely, that the usual type (excluding mechanical and organic types) encountered today, in city life particularly, is a functional nervous disorder. While an improper diet, consisting of foods too greatly refined and containing too few vitamins, sedentary habits and other current explanations of the condition are important, the fundamental idea always to be borne in mind is that constipation manifests itself only in a soil which has been prepared through the agency of an unstable nervous system. This may be congenial or it may be acquired through the unceasing combat with the demands of modern civilization. Treatment can never be routine. Individualization is imperative. The management of constipation must begin with its prevention, and this must start in infancy. Infants should be held in a squatting position with the thighs flexed on the abdomen. Children should not be compelled to sit with dangling feet on high toilets; a stool should be placed under their feet. This simple procedure is also helpful to adults with weak abdominal muscles. The establishment of a regular time for defecation (after each meal, or at least after breakfast) and strict adherence to the schedule are essential. The act should never be hurried, and the mind should not be unduly concentrated on it. As regards diet, the food must be sufficient in quantity, and must be ingested at regular hours. The teeth should be in good condition in order to masticate it properly, but it should not be fletcherized. The character of the diet must always be modified to suit the individual; what is good for the lean is not good for the obese; what benefits the atonic type may harm the spastic type. The presence of an associated disease, such as diabetes or ulcer, obviously calls for a modification in the character, variety and preparation of food. Generally speaking, a proper selection of food should be made from all the fruits and green (above ground) vegetables, since these are rich in cellulose and contain the necessary salts, vitamins and organic acids. In spastic constipation many of these foods are not permitted because of their high cellulose content. For the same reason bran may be harmful. For such patients the underground vegetables and starchy foods, such as potatoes, rice, macaroni, strained cereals, and white bread instead of whole wheat bread, with the avoidance of skins, seeds, etc., are desirable, but for a short time only. Later, stewed fruits and well cooked green vegetables may be allowed. While a certain amount of meat is advisable, it should always be taken in moderation. Although the vegetable proteins are perhaps not so quickly assimilated as those of animal origin, they nevertheless meet the requirements for good health. A sufficient amount of water is always required —hot water, especially on rising, for the spastic patient, cold for the atonic. Various hydrotherapeutic measures, such as hot baths and hot applications, preferably in the form of abdominal packs, aid in relieving spasm. For emaciated and visceroptotic patients a well fitted abdominal pad is helpful. In all cases a moderate amount of exercise, particularly of the abdominal muscles, is required. In addition to active exercise, abdominal massage and electricity are indicated. In the spastic type light massage and the galvanic current are helpful, while in atonic cases vigorous massage and an interrupted sinusoidal current may be employed. Deep breathing exercises are always beneficial. Enemas are useful in cases of rectal constipation (dyschezia). Transduodenal lavage and colonic irrigations, when properly administered, are temporarily advantageous especially when there is an intensive toxemia. In the spastic types the temperature of the solution should be about 100 to 104 F., in atonic cases about 90 F. Drugs are rarely indicated, except in cases of acute illness or when the constipation is the result of such conditions as senility, anemia, cancer, diabetes, kidney disease or insanity. It is inadvisable to prescribe cathartics as a routine; if they must be used, they should be selected with extreme nicety to fit the individual case. Cascara is suitable for aged men and pregnant women. Saline are not appropriate for dyschezia. Liquid petrolatum, agar-agar and psyllium seeds will not harm any one, and are often distinctly beneficial. Toxin-absorbing agents as koalin, and the various toxin-preventive substances, such as lactose and lactose-dextrin are decidedly worthy of trial. In spastic cases sedatives (bromides, atropine, belladonna, hydrastis, etc.) are distinctly helpful. In atonic cases and in those with nervous depression, strychnine, which is supposed to stimulate Auerbach's plexus, and other tonics are indicated. Thyroid and ovarian substances are helpful in suitable cases. Psycho-therapy has served as a most important means of approach in correcting nonorganic constipation.

ARTHRITIS

It is urged by Robert McE. Schauffler, Kansas City, Mo., (*Journal A.M.A.*, November 19, 1927), that every physician use some simple clinical classification for arthritis and attempt to place his cases in one of these groups and direct his attention to the major characteristics of the group in his study and treatment of the individual case. It is necessary to distinguish between those cases in which the discovery and treatment of a local focus are all important and the other groups in which they are of little value. Every case of infectious arthritis imposes a peculiar obligation on the physician in charge. He must not be satisfied even if the symptoms subside, but must search earnestly for the focus of infection and attend diligently to the general health of the patient. In the first year it is almost always possible to effect a cure; after five years, perhaps nobody can do so. In subacute and chronic cases it is undesirable to allow patients too much rest. If one keeps them down too long or knocks them down by too strenuous treatment, they may never resume any useful activity. No case of chronic arthritis should be accepted for medical, surgical or mechanical treatment, until the history has been carefully considered and a thorough physical and laboratory examination has been made.

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EDITORIALS

THE TREATMENT OF INFECTIONS

There is probably no more interesting field for therapeutic investigation than that offered in the search for some chemical agent of value in the treatment of the ordinary bacterial infection. It appears that the hope persists that some elusive chemical agent exists, the discovery of which awaits only the persistent efforts of the research worker. When it is found the problem of treating infections will be solved. While it would be foolish to predict that no such agent would ever be found, it is well to bear in mind that to date it has not been discovered and that we have no sterilizing chemical agent that will kill bacteria when once they have invaded the living tissues of the host. Until such time it is well to dismiss entirely from our minds the value of any and all chemical agents in the treatment of so-called surgical infections. Unless this is done, a great deal of valuable time is lost, and more harm than good is apt to be done. Lord Lister made the epoch making discovery that contaminated wounds could be made to heal per primum by the use of a chemical antiseptic, but no Lord Lister has arisen since that date to show how these organisms can be prevented from damaging the tissues after infection is established.

The basis of a rational treatment of infections rests upon a proper understanding of the mechanism of defense which the body brings into play as soon as the tissues are invaded by bacteria. We know a good deal about this mechanism of defense, thanks to Ehrlich, Metchnikoff, Wright, Allen, Peterson and others. From a biologic standpoint it would be difficult to conceive of the continued existence of mankind without the presence of an effective defense against the old age menace of his life. The treatment of infections therefore resolves itself into a study of the various factors of which this defense mechanism is composed. Briefly sketched this mechanism of defense consists of certain biological and chemical processes originating in the body, which have for their ultimate object the destruction of the invading bacteria or their limitation to the least possible area. With our present knowledge, when treating infections, it is our sole duty to discover how best we can aid the body to bring into play these biological and chemical processes that have been developed no doubt as the result of evolutionary changes for the purpose of defense. First and foremost is physiological rest. It is interesting to note how this principle alone constitutes the basic factor, and almost the only one in a wide variety of infections involving many different organs of the body. It is so extremely simple and so devoid of the ordinary complexity of therapeutic endeavor that its significance is constantly overlooked. The organism itself points the way as shown by the spastic muscles and flexed limb in the presence of an infected joint, the rigid abdomen, the distended bowel in peritonitis. Our contribution to this effort of nature is to immobilize the limb, withhold cathartics and food in peritonitis and give opium. Many other illustrations could be submitted to show the beneficent action of physiological rest in the treatment of infections.

When we analyze the results that have been accomplished in the field of biological therapeutics which aims toward the discovery and use of agents to stimulate the organism to greater activity in its own defense against infection, we find a good deal of confusion. In biological therapeutics we find the same limitations in efficacy as in chemical therapeutics. As in the former, so in the latter, while brilliantly successful as a prophylactic, they both have been disappointing in treating infections already established. Vaccines, sera, and nonspecific proteids of various kinds are used extensively, but nothing approaching an authoritative, standard procedure has been found. This effort of therapeutic endeavor undoubtedly rests on sound biological reasoning, and to that extent offers a hopeful field of work.—M. N. H.

DIAGNOSTIC STANDARDS OF TUBERCULOSIS

In 1917 a committee on Diagnostic Standards, organized by the National Tuberculosis Association, set to work to formulate as simply and accurately as possible standards and criteria for the diagnosis of tuberculosis. The seventh edition of Diagnostic Standards for Pulmonary and Glandular (Hilum) tuberculosis was published November, 1926, in booklet form by the Committee, which at present consists of the following: Dr. John A. Smith, chairman and secretary, Dr. Fred H. Heise, Dr. Alexius M. Forster, Dr. Henry D. Chadwick, Dr. Clarence L. Hyde, Dr. Walter L. Rathbun and Dr. J. Burns Amberson, Jr.

Minimum standards in the diagnosis of pulmonary tuberculosis are listed as follows:

1. When constitutional symptoms and definite past history are absent or slight, there should be demanded definite signs in the lungs, including persistent rales usually in the upper half of the lung or definite and characteristic parenchymal changes as shown by the x-ray, or the finding of tubercle bacilli. (By "persistent" is meant that

the rales must be present after cough at two or more examinations, the patient having been under observation at least one month.)

2. In the presence of constitutional symptoms, such as loss of weight and strength, etc., as defined above, there should be demanded some abnormality in the lungs on physical or x-ray examination or both (but not necessarily rales.)

3. Usually a process in the upper half of the chest should be considered tuberculous and a process in the lower half non-tuberculous, until the contrary is proved.

4. Hemoptysis or pleurisy with effusion is only presumptive evidence of the disease.

5. Pain in the chest and shoulders, night-sweats, digestive disorders, etc., require careful examination of lungs for evidence of the disease. The presence of any extra-pulmonary tuberculous lesion necessitates careful examination of the lungs. This includes especially fistula in ano, adenitis, joint tuberculosis, etc.

6. In every doubtful case one should demand that the patient be kept under observation and a record kept of pulse, temperature, weight, etc., for at least one month, with repeated sputum examinations, before a definite diagnosis is made. The importance of careful and thorough observation for at least one month is to be emphasized.

7. Tuberculin tests and other special laboratory diagnostic methods are of use only when in the hands of those specially trained and experienced in their interpretation.

The booklet also includes precise definitions of symptoms commonly encountered, classifications of diagnosis according to lesion and recommendations for the disposition of patients according to stage of disease.

"Diagnostic Standards" may be obtained free from the Indiana Tuberculosis Association, 1220 Meyer-Kiser Bank Bldg., Indianapolis.

OVERTAXING STUDENTS WITH OUTSIDE WORK

We believe that parent-teachers' associations ought to discuss the question of how much work may be saddled upon high school students to be done outside of school hours. Recently we have learned that it is quite the practice of high school teachers to ask students to do an amount of reading and other eye work that if done in a creditable manner would leave the student about three hours of sleep during every night and no time for recreation or amusement. This, we think, is a very serious mistake and one that ought to be corrected. There is no reason why a high school student should not do a certain amount of work outside of school, but to assign lessons that require the time that should be used in rest and recreation is an injustice and one that has its effect upon the physical and nervous condition of our young people. We are well aware of the fact that many high school students are dissipating far beyond reason in the way of parties and social amusements that sap their physical and nervous vitality, but that is no reason why our high school teachers should prescribe an amount of outside work that even the studious pupil is unable to do even if time is spent at nothing else. The father of one high school girl reported that an endeavor to read what had been assigned for his daughter for one evening's work required close application from about seven-thirty in the evening until four the following morning, and then he read rapidly with an idea of seeing just how much time would be required for the work assigned. The daughter had been putting in late hours in an endeavor to cover the reading required by her teachers, and was showing the effects of that form of strain by a breakdown of the nervous and physical condition, and it was quite appropriate that the father should determine for himself just how much of a burden was placed upon his daughter in the effort to give her a comprehensive education. There is reason in all things and there ought to be some reason in the assigning of outside work for pupils in our public schools.

PROPOSED RELIEF FOR SCARCITY OF COUNTRY DOCTORS

The National Grange, representing eight hundred thousand members, while assembled at Cleveland, Ohio, in November, passed a resolution calling upon the House of Delegates of the American Medical Association to assist in correcting the scarcity of country doctors. Attention is called to the threatening general breakdown in rural medical service caused by the dwindling supply of country doctors, and as a remedy the Grange suggests certain reforms in medical education, chief of which is a lowering of the present standards. It is suggested that competent doctors for the rural districts may be created by permitting the high-school graduate to take a four-year medical course, and adding to this a year of internship in a general hospital, after which he should be considered capable of putting up with country medical practice.

Perhaps those people living in the country districts would be satisfied with medical men who do not have the broad education and training of the medical men who practice in the cities, but we are inclined to think that such is not the case, and our reason for this is that even if one of our present-day highly educated and well-trained medical men locates in a rural community, the people of that community seldom if ever appreciate his qualifications and show it by patronizing him to the exclusion of nearby city physicians who perhaps are even inferior in education, training and experience. It is human nature to think that you can get something a little better away from home, and merchants and professional men feel this response to the urge by noting that their neighbors, oftentimes without good reason, will

go far distant for merchandise or service that can be procured at home and perhaps even be of better quality. We are quite willing to admit that this constant raising of standards for the practice of medicine is making it more difficult all the time for very worthy persons to become physicians, because of the prohibition brought about by the large expenditure of money and time required to meet the obligations imposed upon one who desires to treat the sick, according to standards prescribed for those in the regular medical profession. Furthermore, with the tendency of a large number of people to minimize the value of the services of a high class physician, which is emphasized in the general low average of income accruing from practice, there is less incentive for any young man, even though he can afford it, to study medicine. However, this does not justify a lowering of the bars as to qualifications for the practice of medicine, for the public in country as well as city deserves and should have the best service that can be secured from men who elect to care for the sick. On the other hand, the public owes something to the members of the medical profession, not the least of which is recognition of the fact that skilled service should be paid for adequately, and particularly by those who are amply able to pay. It is generally recognized that medical men never object to caring for the worthy poor, without money and without price, but they do expect patients who are amply able to pay, to be willing to make up for the charity work that is done, though altogether too often the very opposite is the spirit manifested. Thus the wealthy, or a considerable portion of that class, are very apt to say that because they have money is no reason why they should pay any more for medical services than any one else, and too often they consider medical service as something that should be bought and sold the same as merchandise. It is this sort of an attitude prevailing among well-to-do people in many localities that keeps the members of the medical profession in that particular locality bound to a low economic standard, and the knowledge of such conditions deters many young men from studying for the medical profession. To a more or less extent, but even with more force, this spirit prevails in the rural community where the inhabitants rather generally feel that the family physician in the community should charge them very low rates and certainly rates that are not in keeping with those charged by city doctors. In fact, many people in the rural districts will go right past a well-educated, well-trained and experienced medical man in their immediate vicinity and consult city physicians and pay more for the service. We have contended that in some measure this tendency is due to the lack of confidence on the part of the physician in his own ability, and his willing acceptance of minimum charges; so when you come right down to cold facts, if a man has ability the public is very apt to appraise that ability higher if the one possessing it also makes a high appraisal, and ability and good service should command and receive adequate compensation. The trouble with the rural communities is that the inhabitants there do not appreciate good service which they may obtain right at home, and, on the other hand, the good physician who locates in a rural community does not seem to appreciate the fact that because he is in a rural community is no reason why he should not be treated as well as his brother practitioner in the city. The whole picture tends to discourage the young medical graduate from locating in the country, and he cannot be blamed for seeking more fertile and pleasanter fields for his life work.

Even if there were some way by which we could separate the medical graduates so that those who are best trained will go to the city and those who are least trained will go to the country, such an arrangement would not prove at all satisfactory, and the residents of the rural communities would be the ones to put up the first howl. The solution of the problem does not lie in lowering the standard, but rather in educating the people in the rural community to appreciate good service that is rendered right at home and be willing to pay adequately for it. In sparsely settled communities it may be necessary to guarantee the local physician a yearly income that is consistent with an income that could be earned in a more populous community by the same physician. Furthermore, the argument put up by the National Grange, that by lowering the standards for the practice of medicine it will encourage more country boys to become physicians and locate in rural districts, is not sound, for at the present time a considerable percentage of the young men who elect to study medicine are from the rural districts but after graduation they do not elect to return to their homes, and for economic reasons already pointed out.

To our notion the American Medical Association, through its house of delegates, should answer the requests made by the National Grange by pointing out plainly the economic reasons why physicians do not go to the rural districts, and suggest that it is up to the inhabitants of the rural districts to put forth some effort themselves to change conditions. In passing, the members of the National Grange should be reminded that giving the rural districts poorer doctors will not solve the problem, nor will the inhabitants be satisfed with such a solution. Make the practice of medicine pleasanter and more profitable in the rural districts and there will be no dearth of doctors for those localities.

THE MEDICAL PROFESSION AND COSMETICS

Not long ago newspapers contained the announcement that the *American Druggist,* a trade journal devoted to the pharmaceutic industry since 1871, had been added to the series of publications owned and controlled by the International Publications, Inc., of which William Randolph Hearst is president. Almost coincident with this announcement, the policy of that periodical seems to have changed from that of one which aimed at —even if it did not always hit—scientific cooperation between the pharmaceutic industry and the medical profession to one devoted largely to attacking scientific medicine and the usefulness of the physician. The issue for November, 1927, contains a somewhat satiric comment concerning the medical profession by O. O. McIntyre, whose first name has been alleged to be "Oracular." It contains also an article by one Alice (Hyphen) Esther Garvin of New Haven, Connecticut, who, according to the editor, "thinks the doctor's idea is all wet." Apparently, Miss Garvin has suddenly developed the quaint notion that the American Medical Association is endeavoring to secure legislation which will make it necessary for druggists to sell cosmetic preparations only on prescription. This extravagant straw man the lady then devastates with ridicule.

The American Medical Association is holding strictly to its policy of protection of the public in all matters related to health, asking only that the presence of dangerous ingredients in the few cosmetic preparations that contain them be so indicated as to give the public the opportunity of knowing what risks it may run in using them. Miss Garvin's article is full of ridiculous insinuations relative to the motives of the medical organizations, and of warnings not justified by any actual evidence. Perhaps the *American Druggist* is trying to build circulation by sensationalism—a process not unknown in the other publications of William Randolph Hearst—*Jour. A. M. A.,* Nov. 19, 1927.

A COMPARISON OF FEES

A fee bill of the Kings County (New York) Medical Society adopted in 1835 is interesting in showing that increase of fees for professional services rendered has not kept pace with the increase in the cost of living or the compensation awarded those following almost any other vocation in life. For instance, in 1835 some of the fees were as follows: Vocal advice, $5.00; letters of advice, $5 to $20; one visit, $2; vaccination, $1 to $5; introducing catheters for the first time, $5; reducing a simple fracture, $5 to $20; compound fracture, $10 to $30; enucleation of the eye, $75 to $100; removal of tonsils, $20 to $25; incision of the eardrum, $15 to $25; lithotomy, $100 to $125; trephining, $75 to $100; difficult labor, $25 to $50; hernia operations, $100 to $125; extraction of cataract, $125 to $150. Such were the fees at a time when ordinary or common labor could be procured for from fifty to seventy-five cents per day and other things were in proportion; eggs were from six to eight cents per dozen, and the very best steaks could be procured for eight to twelve cents per pound. Fresh calves' liver, almost a delicacy now, in those days was given away. There are items on the fee bill of 1835 that are interesting, as for instance, the *curing* of gonorrhea is placed at from $8 to $25; the *curing* of syphilis from $10 to $25; paracentesis of the abdomen is placed from $10 to $25, and of the thorax from $25 to $50. However, in the main the fees are almost as large as the fees obtained today in many localities. If the fees charged in 1835 were fair and just, then the fees charged today are not fair and just, though the service we are rendering is infinitely better. Many physicians are complaining because they have trouble to make both ends meet in a financial way, but as a matter of fact they have no one to blame but themselves. If they value their services lightly, the public is going to do likewise. Physicians render skilled service. To fit themselves for the practice of medicine they spend a large amount of time and money and there is no reason why they should not be compensated for the capital invested, to say nothing of being adequately paid for expert services. A fee bill for 1835 should not be a guide for 1928.

EXTRAVAGANT NEWSPAPER PUBLICITY

We are much in sympathy with the comment made by the editor of *Southern Medicine and Surgery* (October, 1927) regarding the undue publicity given Dr. Chevalier Jackson, of Philadelphia, concerning his recognized skill in endoscopy and the melodramatic way in which many of his cases are written up in the lay press. Judging from newspaper reports, the stuff is well calculated to lead readers to think that the kind of work done by the endoscopist of international fame is not done anywhere else, whereas it is a matter of general knowledge among physicians that bronchoscopy and esophagoscopy are done skillfully in practically all of our cities. The point is well taken by the editor of *Southern Medicine and Surgery* when he says that our newspaper men should be told of these facts and dissuaded from writing up commonplace procedures as though they are miracles and thus giving an unmerited slap to our own physicians and at the same time advertising distant doctors in an improper and misleading fashion. Further comment is as follows: "We can understand the stories of the rescue of buttons, peanuts and pennies from the windpipes of children when the stories find

their way into newspapers without the connivance of the rescuer, but we are convinced that only very rarely will this occur if the rescuer seriously attempts to escape such publicity."

The case which brought about this criticism has been duplicated in Indiana more than once. For instance, a child in one of the Northern Indiana cities made an unsuccessful attempt to swallow a button and it became lodged in the esophagus. The case could have been handled successfully, as many similar cases have been handled successfully, right in the home city of the patient, but no local physician was consulted, and the newspapers made a feature of the fact that charitably inclined people raised a purse of several hundred dollars to send the patient several days later to Philadelphia where the marvelous feat of removing the impacted button by esophagoscopy was credited to one of the few men in the world who could do such work. (?) If the results were as represented, no criticism could be offered, but at a matter of fact such incidents are occurring in Indiana and every other state with considerable frequency and without any blare of trumpets or spectacular newspaper publicity. As pointed out by the editor of *Southern Medicine and Surgery,* such incidents not only are an injustice to the medical profession, but an injustice to the patients who suffer unnecessary delay and go to great expense in going away from home for something that is easily obtained at their own doors.

PATRONIZE THE ADVERTISERS

It would take us about ten years to use up the hotel requisitions covering rooms and meals that have been offered by advertising agents in exchange for advertising in THE JOURNAL. In these days no medical journal accepts advertising on a trade basis or even at a discount to any one. Even the old time advertising agents who expected all the way from twenty-five to fifty per cent commission on contracts placed, and in addition exacted valuable perquisites in the way of free reading notices, have been cast into the discard by most of the medical publications.

It costs real money now days to publish a medical journal—probably four times what it did twenty years ago—and in consequence the question of income is a matter of close figuring, with special favors to none. Then, too, the advertising pages of the official medical journals are clean and trustworthy, an unusual effort being put forth to protect the readers from imposition. The medical frauds, near-frauds, and advertisers of questionable reputation are denied admission to the advertising pages of every reputable medical journal. This should be appreciated by the readers, and to the extent of extending patronage to the firms that advertise in the state medical journals. From the time of its establishment up to the present moment, THE JOURNAL of the Indiana State Medical Association has followed the inflexible rule of admitting no advertising of a questionable nature, and while following this policy has meant the loss of thousands of dollars worth of advertising that might have been secured, yet the policy was adopted and has been followed with the one idea in view of maintaining a high standard for THE JOURNAL while at the same time protecting to the fullest extent the interests of the physicians of Indiana. The advertisers in our JOURNAL know that they are in good company at all times, and we believe that they have a right to expect that the physicians of Indiana will reciprocate by giving them patronage instead of patronizing firms less responsible who cannot under any circumstances be represented in the advertising pages of THE JOURNAL.

PARTIAL PAYMENTS FOR MEDICAL SERVICES

IN a previous number of THE JOURNAL we called attention to the fact that the average citizen has mortgaged his income for the future in order to supply himself and family with not only such luxuries as automobiles, radios, electric washing machines, and fur coats for the wife and daughter, but sometimes for the real necessities of life. When his pay-day rolls around he has so many partial payments to make on debts contracted that he has nothing left to put in a savings account, and nothing left for any extraordinary or unusual expenses that have come up, in which latter class belong bills for hospital and medical service. Occasionally a little is left from the pay check, and perhaps some of the payments have been completed, thus giving opportunity for going in debt on the same plan for something else. The bill for medical services receives scant or no attention. Sometimes nothing is left from the pay check with which to pay the physician, and in other instances when something is left the amount is so small that the owner is ashamed to offer it to the physician. The partial payment plan has been "sold" to him, and, on the theory that he can enjoy the comforts or luxuries while paying for them, he grasps at the opportunity to improve his condition as well as give himself the appearance of prosperity by taking up with the partial payment plan for everything that he buys. He seldom looks out for the rainy day when he will be without work, or for the unfortunate occurrence of sickness or injury, and in consequence he has not provided financially for such emergencies. No wonder, then, that the family physician is not paid or at best is paid after long waiting. We are convinced that inasmuch as the partial payment plan is offered to the ordinary industrial worker by merchants of every class, the physician will do well if he makes it known in an unmistakable way that he not only is entitled to payment for his

services but that he will be as lenient as the dealers in automobiles, radios, fur coats, diamonds, and luxuries purchased so freely by all classes of people, and permit the partial payment plan in settlement of the account for medical and surgical services rendered. In accepting this plan the patient does not lose his self-respect or his temper by either omitting to pay his doctor and becoming classed as a deadbeat, or paying it under protest months or years after the debt has been contracted. Furthermore, the physician who really needs the money for the services that he renders is going to be better off financially and every other way by the adoption of some policy which will permit some kind of a settlement of any and all accounts with his patients, even though it is made on the payment plan and over a series of months or years. Therefore, we offer the suggestion that the partial payment plan for industrial workers is worthy of adoption on the part of physicians whose practice is not confined wholly to the well to do.

WASTE OF TAXPAYERS' MONEY

At the West Baden session of the Indiana State Medical Association there was considerable discussion concerning the abuse of free service at the state hospitals in Indianapolis. When thoroughly analyzed it was discovered that most of the abuses could be traced right back to the physicians in the county from which patients had been referred. The law not only requires that a patient for the Riley or Long hospitals must be sent through an order of the judge of a county court, but also upon the recommendation of a reputable physician who must give a statement to the effect that the patient is indigent and deserving of free service, and that appropriate care can not be received in the home county. Thus it would seem that some physician always is responsible for the referring and acceptance of a patient for free attention at the state hospitals though the county from which the patient comes is required to pay for everything excepting the medical and surgical services.

Concerning the abuses of this service, and the manner in which it forms a waste of taxpayers' money, a discusson at the December meeting of the Madison County Medical Society throws considerable light. Statistics were offered showing that Madison county has contributed $135.00 for every patient sent to the Riley hospital in Indianapolis during the preceding two years. In 1926, forty-nine patients were referred from Madison county to the Riley hospital, and until October 1, 1927, there had been forty-eight more. For these patients the county auditor issued warrants and paid the Riley hospital, $13-057.57. An investigation shows that many of these cases had no justification for being sent to Indianapolis at the expense of the county. It was shown that the county has paid to have patients sent to the Riley hospital for the removal of tonsils, and that the county paid more for hospital bills in Indianapolis than it would have cost to have had the work done at home and paid fair fees to surgeons for the operations. The worst feature, as pointed out in the discussion, is the fact that it is an imposition on taxpayers to pay hospital bills for people amply able to pay hospital expense and a surgeon a reasonable fee. A number of specific instances were cited to show that the people sent to the Riley hospital were not indigent. In one instance a factory foreman, owning his own home and an automobile, sent two children to the Riley hospital for tonsil and adenoid operations, and made a sworn statement that he could not afford to have the work done at home. Similar instances were cited in connection with the sending of patients to the Robert Long hospital. It was stated that during the last two years Madison county alone has been contributing monthly something like one thousand dollars of the taxpayers' money to the two hospitals mentioned.

We believe it is appropriate to remind the physicians of Madison county that they can stop the abuses of which they complain if they will build a bonfire under the doctors and the judges who are responsible for the referring of self supporting patients to either the Riley or Long hospitals. There is no desire on the part of any reputable member of the medical profession to curtail the legitimate use of the state hospitals by those worthy of charity, but aside from taking work away from local physicians who deserve it, the taxpayers' money is being wasted in paying hospital fees for those able to pay for themselves, and the abuse of charity tends to produce loss of self-respect and encourage dependency. The physicians themselves have it within their power to stop this abuse of service at the Long and Riley hospitals if they put forth an effort to do so.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

A Southern Newspaper says that the reason that the country movement for doctors will not succeed is because there aren't tonsils and ap-

pendices enough left on the farm to support the movement.

THOSE who are interested in the liver diet for anemia will find some excellent recipes for cooking and serving liver, that have been taken from English and French sources and published in the *Journal of the A.M.A.* for October 15, 1927.

THE Proceedings of the Mayo Clinic are published in pamphlet form and widely distributed. The enterprise is being copied in many localities, and even in Indiana. Is this an educational or publicity stunt? We are asking for information.

THE Illinois State Medical Society is honoring its past presidents by giving them a certificate of service. Nineteen past presidents have received this certificate of appreciation and no doubt it will be given regularly to all presidents of the future.

FORTY-THREE percent of the children examined at seven recreational camps operated by social agencies of Indianapolis during the past summer were found by public health officials to be under-nourished. What an opportunity for the uplifters and welfare workers!

WE are very much pleased to note that the American Society for the Control of Cancer is issuing some bulletins for publication in the lay press, and newspapers very generally are using the bulletin for the education of the public concerning the prevention and cure of cancer.

JULIUS WAGNER VON JAUREGG, professor of neurology and psychiatry in the University of Vienna, has been given the Noble prize in medicine for his malaria treatment of paresis. He has been using fever-causing toxins to treat paralysis since 1887, and since 1919 his malaria method has been in wide use.

DISTENTION of the stomach and not the kind and quality of the food that is eaten is responsible for drowsiness after eating. This was proved by two physicians connected with Rush Medical College who experimented by noting the effect when one swallowed a balloon attached to a stomach tube and the other blew it up. In a few moments the subject became drowsy and had all the symptoms of having over-eaten.

A member of the Indiana State Medical Association says, in a communication to the editor, "I think if we would jump up and down and cuss occasionally the politicians would have more respect for the medical profession. We are too passive for our own good. This county is being run or controlled by the lawyers, preachers and leagues. Why can't we have a few physicians occupying positions in our legislative bodies?"

DR. W. A. PUSEY, former president of the A. M.A., says that malpractice suits are usually cases of vindictive patients, of lawyers who are not in business for their health, and of doctors who want to satisfy a grudge or a jealousy. Here in Indiana we have learned that the latter cause is very prominent, for without the support of some physician the malpractice suit falls flat. What is true in Indiana is true in every other state in the Union.

SOME of the arrangements for the Gary session of the Indiana State Medical Association already have been decided upon, and one of the decisions pertains to the matter of scientific meetings. The former practice of dividing the association into sections where special papers are presented will be done away with and there will be only general meetings for the Gary session, though such an arrangement is not to be considered as a precedent for the future.

JUST why tonsil and adenoid cases from any populous community in Indiana should be sent to the Riley and Long hospitals for free medical service but with hospital expense charged to the county from which the cases come, is hard to understand. Certainly they do not do any better work on ordinary cases in either the Riley or Long hospitals than can be done in any city or good sized town in Indiana. What are the physicians doing to prevent these abuses?

IN a talk before the secretaries and editors conference in Chicago during November, Dr. Morris Fishbein, the editor of the *Journal of the A. M. A.*, said that medical economics should be brought to the attention of all medical men, and that each county medical society should have one meeting a year devoted to the subject. We have mentioned this time and again in THE JOURNAL and again offer it as a suggestion worthy of being followed by every county medical society in Indiana.

"I KNOW no more unjust proposition than that which has been established by one of the hospitals of this country that not more than $200 can be charged in that hospital for any medical service. To take a man in there who would pay $25,000 or $250,000 for an old painting and charge him $200 or even $2,000 for carrying him through one of the greatest crises of life is economic stupidity and an economic outrage on medicine."—W. A. Pusey, in the American Medical Association Bulletin, October, 1927.

The Bureau of Publicity of our Association has released an article on "Nature Curing or Physical Therapy" for publication in the lay press. It is a splendid article and points out the limitations, uses and abuses of physical therapy methods of treatment. We hear that a very large number of the newspapers of the state have published the article, and we hope that physicians will encourage all newspapers to do so. Incidentally, we hope that every physician in Indiana will use his influence with his home papers.

Well, just as we thought, the manufacturers of physical therapy apparatus are going direct to the laity, though they ask physicians to write prescriptions telling just how the physical therapy apparatus must be used in order to secure the best results. In other words, a physician is to tell how to use the equipment, and then his connection with the matter is ended, for ever afterward the laity will know how to prescribe for itself. Isn't it surprising how often the physician is made the cat's paw of manufacturers of all kinds of medicinal agents and apparatus which is sold to the public?

The American Medical Association, through its legal department, is preparing a bill to be introduced in the several state legislatures in which the term "Doctor" will be defined and an effort made to prevent the title being employed by any except those who have earned it. We don't believe that such a bill, even if passed by all of the legislatures, will amount to three whoops in Hades, for as a matter of fact it is the public that gets to calling corn-parers, medicine peddlers, chiropractors, and others of their ilk "Doctor," and you can't prevent the public from using the term.

"It is the duty of physicians to discourage those who contemplate taking a correspondence course in nursing. In the end, women so taught will be a disappointment to themselves, an irritation to physicians, and a danger to the public." —(*Journal A.M.A.*, May 31, 1913). The above is as true now as it was in 1913, and we desire to emphasize it because at the present time there is a so-called Academy of Nursing, with offices in the Medical Arts Building, of Fort Wayne, which is trying to secure students at one hundred dollars in advance to take correspondence courses in nursing.

One of the reasons why physicians have such a hard time collecting that which is due them is because they have not educated the public to pay bills promptly for professional services rendered. The average person will pay his automobile repair bill or even his bootlegger quicker than he will pay his family physician, but the reason for this is not difficult to find. The automobile repair man demands cash for his services when the work is completed, and usually the bootlegger requires his cash in advance. The average physician does not ask his patron for money for three, six or even twelve months after the services have been rendered. Is it any wonder that he has difficulty in making collections?

Will general physicians ever learn to use argyrol cautiously in the eyes on account of the possibility of causing argyrosis through extended use? Some general physicians would stand better with their patients and with the medical profession if they ceased to prescribe for eye conditions about which they know little or nothing. Patients frequently consult ophthalmologists for relief of argyrosis caused by the continued use of argyrol that has been prescribed by some family doctor. Sometimes the physician himself has dispensed the medicine, but occasionally he has told the patient what to get at the drugstore and ever afterward the patient has thought that argyrol would be good for whatever ocular ailment presented.

No ethical physician will exploit himself in the lay press nor willingly permit his name to be given undue prominence in connection with medical affairs of any kind. However, much friction could be avoided if physicians generally made it a rule to give newspaper reporters all of the information or news concerning medical matters or even cases, providing that only such information as the public is entitled to is given, and the physician himself withholds his own name. Oftentimes physicians are in possession of facts that are real news to the public and to which the public is entitled, and it is a short-sighted policy to antagonize newspapers that intend to be only fair in using any information that can be secured. Furthermore, there isn't one newspaper out of fifty that will not respect a physician's request to be spared personal publicity in connection with medical news.

The *Journal of the A.M.A.* under the date of October 15, 1927, pays a deserved compliment to Mr. F. M. Willson, the manager of the Better Business Bureau, of Rochester, New York, who has been unremitting in his efforts to stamp out medical frauds of every description. Mr. Willson is an Indiana product and a few years ago was manager of the Better Business Bureau of Fort Wayne, though his talents were not duly appreciated here and he soon received a call to go to Toledo, Ohio. However, he was too good for Toledo, and Rochester made a bid for him and there he is now, doing some of the finest and most effective work done by anyone connected with Better Business Bureaus in the United States. It is regretted that there are not more men like Willson who sees the danger of permitting medical

frauds to flourish and are effective in putting them out of existence.

ENFORCEMENT of the caustic poison act has been begun. The act became a law on March 24, 1927, but no penalties were to be imposed until September 4, 1927, six months after its enactment. However, its enforcement was not begun until December 22, 1927, when the deficiency bill first provided funds for its enforcement. The law provides in general that dangerous caustic or corrosive acids and alkalis, when in a container suitable for household use, shall bear conspicuous and easily legible labels containing the common name of the substance, the name and place of business of the manufacturer, packer, seller or distributor, the word "Poison" to be in twenty-four point size capital letters. The label shall bear directions for treatment in case of accidental personal injury. Violation of the act may be prosecuted in the federal court, and on conviction a fine of $200 or imprisonment for not more than ninety days, or both, may be enforced.

IT was suggested at the last meeting of the Council of the Indiana State Medical Association that county medical societies should have more meetings with the dentists inasmuch as the two professions have much in common. At the present time there is a tendency on the part of many dentists to pay too little attention to the general condition of a patient who may need teeth extractions or care of apical root abscesses, and in consequence some serious and occasionally even fatal results occur as a direct result of the lax cooperation between the attending physician and the dentist. On the other hand, there are some physicians who fail to recognize and appreciate the danger connected with diseased teeth, and the patient suffers in consequence. A discussion of these problems in a joint meeting of dentists and physicians will go a long way toward benefiting both professions and the public as well.

THE *Bulletin of the National Women's Medical Association* is crowing because the Sheppard-Towner Act gives medical opportunity for women. It announces that Indiana employs, in addition to its director, three women physicians on its staff. The medical profession of Indiana is not crowing over this condition of affairs and has offered many arguments in opposition to the continuance of the Sheppard-Towner Act. There never was any good and sufficient reason for the passing of the act, for we already have too many bureaus, commissions and officials delving into our private affairs. Of course these enterprises furnish fat picking for the politicians, for they create innumerable salaried offices, and there are three people waiting to grab every salary. When it comes down to medical opportunities for women we feel that the women physicians of America can serve a greater field of usefulness than in carrying out the illogical provisions of the Sheppard-Towner Act.

AMONG state medical associations Illinois for some time past has been a sort of renegade insofar as maintaining a decent standard in accepting advertising for its journal and accepting commercial exhibits for its annual conventions. is concerned. At the conference in Chicago it was announced that Illinois is going to turn over a new leaf and hereafter its journal will not carry objectionable advertising, nor will its conventions be disgraced by commercial exhibits that are condemned by the majority of medical associations of the country. Well, all we can say is that we are pleased to offer the right hand of fellowship and say "God be praised that a sinner has been brought into the fold." The Illinois State Medical Association ought to be a leader in the state medical asociations of the United States, and its conduct should be one to be emulated rather than condemned. Well, we are not the only ones to join the hallelujah chorus now that Illinois has seen the error of its ways.

DR. CHARLES A. L. REED, president of the American Medical Association at the time of its reorganization, and one of the committee that formulated the principles of ethics, is now devoting himself exclusively to literary work. His health articles, syndicated and published in a large number of newspapers throughout the United States and Canada, are intended, Dr. Reed says, to carry the message to the masses. He says he saw, however, that newspaper writing could not be combined ethically with fee-earning practice, for while each is entirely ethical within itself, the two will not mix. Therefore, when he began his newspaper writing he announced to the entire medical profession that he would accept no more patients, and he says that he has kept his word. Furthermore, he does not permit his address to be associated with any of the newspaper articles, and although he admits receiving hundreds of letters asking for treatment, in no single instance has he ever given it.

IT is a well known fact that the chiropractors oftentimes do a lot of harm by kneading, pounding and pulling a patient whose affected parts need quiet. In infantile paralysis in particular a lot of harm has been done by chiropractors who have been trying to "adjust" such cases. Occasionally we hear of a patient dying while undergoing "adjustment" at the hands of a chiropractor. Recently a patient went to a chiropractor's office in Kokomo and died while in the office. The coroner reports that the patient had a dislocation be-

tween the first and second vertebrae of the neck. The chiropractor says that he was "getting ready to make an adjustment but did not make it." Perhaps it will require the courts to settle the question. Will the public ever learn that it is necessary to make a diagnosis before instituting any treatment? No chiropractor ever yet has been able to make a diagnosis that is at all trustworthy. In consequence he applies adjustments to everything that turns up, for to him a patient is a patient.

At a meeting of the New York State Association of Public Health Laboratories in November, Dr. W. L. Aycock, of the Harvard Medical School of Boston, reported his results in the treatment of paralytic cases of poliomyelitis with convalescent serum. He administers a total of forty to fifty ccs. giving fifteen to twenty cc. intraspinously on each of two succeeding days and the remainder intravenously at the time of the first intraspinous injection. He believes that to be effective the serum must be used within thirty-six hours after the appearance of the symptoms. Ninety per cent of his patients so treated fully recovered. This, in his opinion, is a far higher ratio of recovery than can be expected in untreated cases. He believes that in the light of our present knowledge of the epidemiology of poliomyelitis nothing can be done by the health authorities and physicians in the presence of an outbreak of the disease which will be of greater value than the prevention of paralysis by the prompt administration of the serum from recovered cases of poliomyelitis.

Whenever a patient is unusually profuse in his expressions of appreciation and thankfulness for services rendered, it is a good plan to consider the question doubtful as to the receipt of a fee for services rendered, for experience indicates that the patient who is loudest in his praise of his physician is very apt to be one that is slow pay or never pays at all. As an illustration we know of an instance where a woman praised her doctor profusely and persisted in telling him as well as his assistants that he was a Jesus to her as he had performed wonderful miracles in restoring her to health. At each visit the same story was told, until finally the physician, thoroughly tired of the praises showered upon him and the utter negligence on the part of the patient in paying for the services rendered, in exasperation said to his bookkeeper, "Tell her that Jesus appreciates the worship but would like a check." The picture usually changes when the physician asks compensation for services rendered to a patient who is so profuse in expression of satisfaction and gratitude.

To our notion medical schools ought to train men to be family physicians. In fact, it is our idea that without such training we can have no broad-minded and capable specialists. However, when we learn to what length some of the medical colleges go to teach some of the various specialties we wonder if such institutions are not missing the mark and paving the way for the development of a lot of specialists who will be suffering from mental astigmatism insofar as being able to possess and use that broad medical training that is so essential to success, for when all is said and done there is no ailment requiring the services of a specialist that is not in some way influenced by conditions that may not be confined to the special organ under consideration. The best specialist is the one who has had a broad and comprehensive medical training before he took up the study of a specialty, and we are distinctly opposed to any plan that makes it possible to emphasize specialization during student days at the expense of the more general medical education.

Blueberry leaf extract has been proposed for use in the treatment of diabetes. The actual value of the product in the treatment of diabetes has not yet been proved. In consequence the product is not being marketed and will not be offered to physicians in general until its usefulness has been demonstrated. This shows commendable spirit on the part of E. R. Squibb and Son, the manufacturer of the product. However, if we are not greatly mistaken, there are unscrupulous pharmaceutical manufacturers who will take advantage of the published reports which already have appeared in the *Journal of the A. M. A.* and extract of blueberry leaf may be offered as a positive cure for diabetes, even being advertised in the lay press. Proof of the actual value of the product must come from workers who have the necessary clinical opportunities and laboratory facilities on which to base judgment, and until trustworthy evidence comes from that source, physicians should be skeptical of any recommendations that come from unscrupulous pharmaceutical manufacturers.

In all probability every physician abhors war and would like to see some plan put in operation whereby wars could be eliminated. However, until human nature the world over changes its present attitude it is the rankest kind of folly to think that we can be safe if unprepared for attacks of jealous, covetous or pugnacious nations. Therefore, the fact that some well-meaning physicians have been led astray by the sentimental pacifist talk of those who intentionally or unintentionally would make us a prey to aggressors, is a cause for considerable regret on the part of many of us who are just as anxious for the abolition of war as they are and who cannot see the consistency or logic of unpreparedness. It would be just as sensible to do without a police force in any city

in Indiana as to do without the protection of a well-equipped army and navy. Life and property is safer under protection than it ever would be without protection, and right now, with European nations admittedly having more than ten million men ready to go to war at once, is not the time to talk of scrapping our army and navy in the United States.

AT the recent convention of the national association of police and fire surgeons and medical directors of civil service commissions of the United States, held at Los Angeles, the old-time resuscitation methods requiring such devices as the pulmotor and lung motor, as mechanical aids, were condemned, and for the reason that in some instances such devices have been responsible for aiding in causing death. The commission, after thorough discussion of the subject, recommended the discontinuance of apparatus of lung motor and pulmotor type, and encouraged the use of the prone pressure method of artificial respiration, and suggested that the special apparatus of certain standard types be used to secure inhalation of ninety-five per cent of oxygen and five per cent of carbon dioxide. This comparatively new treatment depends upon the recognition of the fact that for every physiologic reason the immediate necessity of gas poisoning is a free flow of oxygen into the pulmonary alveoli, and the oxygen mixed with five per cent of carbon dioxide utilizes the stimulating effect of carbon dioxide on breathing in order to get a high concentration of oxygen in the long run.

A NEW YORK preacher is receiving considerable notoriety through his efforts to cure the lame, the halt, and the blind in his church, through prayer and the laying on of hands. The New York City Board of Health is opposed to some of the methods pursued and claims that there is danger of the spread of some communicable diseases, but the preacher defies the Board of Health and continues with his advertising stunt, and he calls it religion. A woman evangelist is working Indiana along similar lines by attempting to attract attention to herself through cures of the sick in public through prayer. Incidentally she is posing for newspaper photographers while garbed in an abbreviated bathing suit, and as she is fair in face and shapely she is getting the coveted publicity as well as notoriety. Well, high pressure salesmanship oftentimes sells the wares offered, but it is necessary to deliver a good piece of merchandise if you expect the business to keep up, and when you sell something that is largely fraud you are bound to come to some bad end. It is unfortunate that churches oftentimes are used for exploitation and the Christian religion employed to cover a multitude of sins.

THE California Fruit Growers are running a dietetic research department and, very naturally, are proclaiming that the citrus fruits are good for many ills and especially act as an aid in the prolongation of health. In consequence the growers are spreading their propaganda through many of the leading periodicals such as the *Saturday Evening Post, Literary Digest, and Collier's Weekly*. Ostensibly the plea is made that people who do not really feel well should consult a physician (certainly good advice) but, on the other hand, the idea is conveyed to the public that most illness is due to acidosis and for that the one best treatment is lemons or oranges of which people should partake more freely. Simple, isn't it? And not without merit. The propaganda will cost a fortune in advertising, but it will mean ten times the amount in profit to the California fruit growers. As a matter of fact many people under par will not go to the doctor, but follow the suggestion given and conclude that citrus fruits will make them well. In consequence some of the sufferers from diabetes, Bright's disease, tuberculosis, and other diseases which ought to be diagnosed and treated by a competent physician will not receive appropriate attention until valuable time has been lost.

WE used to think that vaccine therapy was about a fifty-fifty shot. This opinion was based upon the fact that in about half of the cases in which the treatment was used the results seemed to be very satisfactory, whereas in the other half it signally failed. The clinical results were the ones upon which the favorable opinion was based. However, we gradually came to the conclusion that some of these favorable results could not be attributed to the vaccine at all but to other measures, and sometimes to no measure at all—other than the recuperative power of nature itself. Now comes the *Journal of the A. M. A.* which tells us that advocates of vaccine therapy, either autogenous or stock vaccine, are not able to advance laboratory proof that is convincing but prefer to depend on the clinical data which is notoriously uncertain. Colds, coryza, upper repiratory infections and the like may respond so promptly to the usual drug therapy or even to no treatment whatever that it is impossible and unfair to make the clinical results a basis of proof for the justification of vaccine therapy. It is just as well for physicians to avoid being over-enthusiastic concerning new methods of treatment until ample time has elapsed to prove results, and especially until we have had opportunity to analyze the results from every angle.

THE National Society for the Prevention of Blindness says, in a circular just issued that, "while blindness from negligence at birth has been reduced by fifty percent there are new haz-

ards which increase the blind population, and most of these hazards are in connection with industry, which alone loses ten million dollars yearly from eye injuries. The education of the blind costs ten times that of normally sighted individuals."

The question of prevention of blindness and the conservation of vision is an economic problem which deserves more serious consideration than given it by most communities. One of the many difficulties encountered is the apathy on the part of many industrial concerns to appreciate the necessity of doing away with the eye hazards of industrial occupations and limiting the eye diseases and eye strain incidental to the daily work of millions of men and women. One of the best ways of presenting this matter to the industrial concerns is to point out the dollar losses, and then they begin to take notice of the importance of the subject. Much has been accomplished, but much more can be accomplished through united effort, and it is to that end that the Society for the Prevention of Blindness is soliciting members and support of the movement.

Tom requests that we emphasize the fact that there is a biographical department at the A. M. A. office in Chicago in which is filed all of the data concerning every physician in the United States and Canada, and before any man coming from outside of the state is taken into any county medical society in Indiana it would be well for the secretary of the county medical society to write to the A. M. A. office in Chicago, or to our office in Indianapolis, and get a direct check on the standing of the individual physician who seeks membership. As an instance of how some county medical societies may slip up, it is reported that a county medical society in Kentucky was presented with an application for membership by a physician who stated that he had been a member in good standing of a county medical society in Indiana but had withdrawn membership a few years previous. Insofar as his Indiana record was concerned it was clean, for he had moved out of the state while apparently in good standing. However, upon inquiring at the A. M. A. office in Chicago it was learned that this man not only had been quacking it for several years but served a short term in the penitentiary for abortion. Very naturally he was refused admission in the county medical society in which he had applied for membership.

An inquiry to the *Journal of the A.M.A.* (November 5, 1927), concerning the use of cycloplegics in refraction work and whether ophthalmologists are using homatropine in refraction work as generally as they did in the past, has been answered so well that we reproduce it in full as follows:

To the Editor: Are ophthalmologists using homatropine in refraction as generally as they had in the past? Please omit my name. M.D., New York.

"Answer: Ophthalmologists in America are using more homatropine for purposes of refraction than ever before. This is particularly true in the cities, where a refractive case can be seen more than once, while in the more rural communities, where frequent visits are next to impossible, circumstances govern the individual case. In patients below the age of presbyopia, it is extremely difficult to perform an even approximately accurate refraction without a cycloplegic, as any ophthalmologist of experience can testify. The public is becoming more and more aware of this fact, owing to the openly aired differences of opinion between the ophthalmic profession and the optometrists. The latter class are barred by law from the use of a cycloplegic and consequently rail at its use; owing to the legal handicap, they are endeavoring to discredit the use of a cycloplegic for refraction. Nevertheless, the fact remains that only by the aid of paralysis of the ciliary muscle can an accurate refraction be performed in a large proportion of acses."

One of the members of the Council on Physical Therapy of the American Medical Association says that "selling" physical therapy to the medical profession is one of the biggest jobs that confront us today. It wasn't much of a job to sell physical therapy to the quacks and even laymen, for on every hand we are confronted with window signs and newspaper advertising testifying to the so-called wondrous cures performed by physical therapy. No doubt physical therapy is one of the great specialties and eventually will find its place when its value has been determined in an unbiased and scientific way. The trouble with physical therapy today is that it is being killed by the manufacturers who are distributing their wares among laymen who are expecting physicians to accept the dictum of laymen as to the beneficial results secured from that sort of treatment. It is this spirit of pessimism and disgust that has resulted in the creation of the Council on Physical Therapy of the American Medical Association, and we sincerely hope that the investigation and the opinion of that council will result in a more widespread appreciation on the part of physicians of what can be accomplished through physical therapy methods. It may be that eventually we will have trained physical therapy practitioners in every community, and especially connected with our hospitals, to whom our cases requiring physical therapy treatment may be sent. However, these trained physical therapists must be physicians or the medical profession never will be "sold" on the value of physical therapy, and thus the benefits of one of the greatest aids to medical practice will have been lost.

PROBABLY every physician has made an attempt to increase the income from the practice of his profession by charging more for services than was charged a few years ago. However, with the cost of living more than doubled within the last fifteen years, it is fair to assume that not one physician in ten has doubled his fee during that time. On the other hand, at present the cost of medical education is almost prohibitive to those who are not blessed with ample means. The expenses of practice, such as office rent, office equipment, laboratory apparatus, x-ray outfits, office assistants, automobiles, telephones, medical books, post-graduate education, physician's license taxes, taxes on medical equipment, narcotic taxes, etc., have made the practice of modern medicine a truly formidable thing from a financial standpoint. Is it any wonder that a few years ago the *Journal of the A. M. A.* after considerable investigation announced that the average physician's net income was not to exceed eight hundred dollars a year? In all probability the average net income of a physician at the present time is not to exceed twelve hundred dollars or about one-half the net income of an ordinary good plumber. In other words, when we come to analyze the situation we find that while there has been a notable increase in the incomes of those following almost every other vocation in life, the physician's income has not increased proportionately. If the physician of today is to survive, he must, perforce, follow business methods in charging fees that are consistent with the times, and adopt business-like methods for collecting that which is his due. In no other way can he hope to survive and maintain his place in society as a professional man.

THE State organization of county medical society secretaries is trying to do something to build up the individual county medical societies. Much is expected of this organization through the interchange of ideas. Some of the lame secretaries will be prompted to get busy and inject a little enthusiasm and enterprise into their efforts to build up a larger and better county medical society. As we have said time and time again, the very life of any society depends upon the secretary, who either can make or break a society. To be a satisfactory secretary is a thankless job, but it pays in the satisfaction of accomplishment. Good programs by local men are possible, but whenever the secretary is at a loss to know what to do, he has our state association office to call upon, and can secure help from that direction through the selection of an outsider to present a paper or clinic. One of the most unsatisfactory features of the secretary's work is the collection of dues, and here more diplomacy is exercised than is justified. To our notion the one way to effect the prompt collection of dues is to attach a penalty for delinquency. Already the delinquents are penalized for not being able to avail themselves of the medical defense feature of the state association for any services rendered during the period of delinquency which may later turn out to be the basis of a malpractice suit, but that doesn't seem to stop the unnecessary delay in the payment of an obligation that should be paid promptly. If delinquents are taxed a penalty of five or ten dollars before they can be reinstated in their local medical society, we will hear little about delinquency, and the county medical society secretaries of Indiana will have a very pleasant time in keeping up membership lists.

RECENTLY a man and his wife who were walking across the street were struck by an automobile driven by a reckless driver, resulting in severe injury to both and perhaps crippling the woman for life as the result of a hip fracture. The driver of the automobile, immediately after the accident, admitted that he was driving a little fast, and that he did not see the pedestrians who were crossing the street at an intersection. Subsequently he made no inquiry as to the outcome of the injuries, and when he was asked if he would not pay the hospital bill he replied that he wouldn't pay a cent, and that a judgment against him could not be collected as all of his property, consisting of a fine eighty acre farm and a town residence, to say nothing of some personal property, is in a joint deed. Perhaps he will change his mind when a suit for damages is pressed, but the point to be considered is the abuse of the joint deed provisions of the Indiana law. Whenever an Indiana citizen desires to avoid the payment of a just obligation he falls back on the Indiana law which provides that no judgment can be assessed against property that is held jointly by man and wife. So far as automobile injuries are concerned it is a well known fact that most of those automobile drivers who are responsible for serious injuries and even loss of life are worthless, and in consequence innocent parties are unable to collect damages or even payment of hospital and medical services in case of injury. What Indiana needs is not only a law like they have in Massachusetts requiring every automobile driver to carry liability insurance for the protection of the public against damage to life and property, but there should be some more stringent method of punishing the reckless and worthless driver who has no regard for either life or property.

THE bulletin of the medical society of Kings County, New York, says that on the air, in the newspaper, on the lecture platform, by means of the movie and health plays are the messages of health handed out. More and more the medical profession through the county medical societies all over the country is being asked to do its share of health education. There are many pitfalls to

be guarded against. In a day or week or month any of us may be asked to write or speak on health topics. Let every member be ready to do what he can, when he can, through the channels provided through the county medical society. The bulletin then publishes a list of subjects that have been arranged by the Public Health Committee of the local medical society. Twenty members of the Society have been selected to talk before the Y. M. C. A. on the following subjects:

"Why a Physician?"
"Your Food and Nutrition."
"Prophylaxis Against Tuberculosis. Why have Tuberculosis?"
"Immunize Yourself Against Disease."
"Tonsils, Adenoids and the Voice."
"When Should a Man Marry?"
"Human Stock Taking. Why have an Annual Physical Examination?"
"The Eye as a Mirror of your Health."
"Syphilis."
"Nerves and Mental Health."
"Gonorrhea."
"Cancer."
"Physical Deformities and their Prevention. Why be a Cripple?"
"The Care of the Skin and Hair."
"Broken Bones."
"How Industry looks after the Worker's Health."
"Deafness."
"These Germ Diseases—Why are They?"
"The Blood Stream and Heart Disease."
"Oral Hygiene."

This list of subjects might well be pasted in the record book of every secretary of a county medical society in Indiana. It offers suggestions as to topics to be discussed.

Dr. M. A. Austin, of Anderson, the energetic and efficient secretary of the Madison County Medical Society, as well as councilor for the tenth district, has some very pertinent suggestions to offer to members of his local medical society which he incorporates in regular letters that he sends out. In the one under date of December 15th he calls attention to the discourtesy and neglect on the part of physicians in not notifying the secretary concerning attendance at banquets, dinners and other entertainments where a knowledge of the number to attend is necessary in order to secure proper service. Then he calls attention to a very important subject and that is the delay in the payment of dues. He says that he doesn't know of any physician who is so hard up that dues cannot be paid on time, and if any man is that hard up he ought to borrow the money and run a bluff at having the dues to spare. He suggests that it is only fair to the other members if delinquents are dropped from membership and not reinstated except by vote of the society and upon payment of the current year's dues plus a reinstatement fee of ten dollars. This is a good suggestion and ought to be carried out in every medical society of the state. The delay in the payment of dues is getting to be very tiresome for those who are responsible for the labor in looking after the dues-paying proposition. Another matter, to which attention also has been called in The Journal, is that of unnecessarily referring patients to the university hospitals in Indianapolis. An announcement is made that the trustee of Anderson township very properly is refusing to send any patients to Indianapolis for anything that can be cared for right in Anderson. If every community in Indiana will adopt a similar course we will hear little about the abuses of charity at the state hospitals. Last but not least, Secretary Austin calls attention to the economic side of the practice of medicine and says that it is high time that physicians pay some attention to their own business problems. He refers to the fact that the average family is spending not only all that it makes but mortgaging all of its earnings for a year or two in advance to indulge in luxuries that cannot be afforded. When sickness arrives the physician is told a hard-luck story which includes unpaid installments on automobiles, pianos, fur coats, radios, fine furniture, and most everything else that high living demands. There is no reason why the physician should pay the penalty for such extravagance on the part of a goodly portion of his patrons.

DEATHS

E. W. Chittenden, M.D., of Anderson, died January 9, aged 64 years. Dr. Chittenden graduated from Northwestern University Medical School, Chicago, in 1894.

William L. Fugate, M.D., of New Castle, died December 28, aged 60 years. Dr. Fugate graduated from Northwestern University Medical School, Chicago, in 1894.

Noah D. Berry, M.D., of Muncie, died January 5, aged 78 years. Dr. Berry was a member of the Indiana State Medical Association and the American Medical Association.

Isaac Ruddell, M.D., of Jeffersonville, died January 14, aged 80 years. He graduated from the University of Louisville, School of Medicine, in 1881, and was a member of the Indiana State Medical Association and the American Medical Associaton.

G. W. Pirtle, M.D., of Carlisle, died at the Sullivan Hospital January 12, aged 60 years. Dr. Pirtle graduated from Rush Medical College, Chicago, in 1890. He was a member of the Sul-

livan County Medical Society, the Indiana State Medical Association and the American Medical Association.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

THE first issue of volume one of the Transactions of the Ball Memorial Clinic, of Muncie, was published December 1.

THE Annual Congress on Medical Education, Medical Licensure and Hospital was held in the Palmer House, Chicago, February 6, 7, and 8.

DR. CHARLES N. COMBS, superintendent of the Union Hospital of Terre Haute, has been selected president of the National Association of Anesthetists.

THE Union Hospital of Terre Haute has recently completed a new surgical unit with seven operating rooms and x-ray and laboratory departments.

THE January meeting of the Madison County Medical Society was held at the Grand Hotel, Anderson, January 17. Dr. John A. McDonald, of Indianapolis, presented a paper.

AT the January 27th meeting of the Muncie Academy of Medicine, Dr. Carl W. Eberbach, of the University of Michigan, presented a paper on "Medical Problems on the Labrador."

THE January seminar of the Indiana University School of Medicine was held in the new auditorium of the Medical School building January 18. Hospital cases and papers were presented.

THE Fountain-Warren County Medical Society held a meeting at Hillsboro, Indiana, January 5 as guests of the Hillsboro physicians. Dr. B. N. Lingeman, of Crawfordsville, presented a paper.

DR. LACEY L. SHULER, of Indianapolis, has been made company surgeon for the Pennsylvania Railroad and the Indianapolis Union Railway Company, succeeding the late Dr. John H. Oliver.

THE Indianapolis Medical Society has elected the following officers for 1928: President, LaRue D. Carter; first vice-president, J. H. Eberwein; second vice-president, Raymond Butler; secretary-treasurer, C. A. Stayton.

THE Muncie Academy of Medicine held its regular meeting January 13 at the Hotel Delaware. Dr. H. D. Fair, of Muncie, presented a paper on "Some Notes from the Race Betterment Conference at Battle Creek."

THE Northeastern Indiana Academy of Medicine held a meeting at the Gawthrop Hotel, Kendallville, January 26. Dr. Charles P. Emerson, of Indianapolis, presented a paper on "Recent Advances in Medical Diagnosis."

A CAMPAIGN for the collection of funds for the establishment of a fitting Indiana memorial to Lincoln is in progress. $1,260,000 is needed. It is planned to erect a memorial in Spencer county, where Nancy Hanks Lincoln lies buried.

A CONFERENCE on rheumatic diseases is to be held at Bath, England, May 10 and 11, 1928. Sir George Newman, chief medical officer of the British Ministry of Health, will act as president of the conference. The local secretary is Dr. Vincent Coates, 10, Circus, Bath, England.

THE United States Civil Service Commission announces open competitive examinations for social worker (psychiatric) and junior social worker. Applications for these positions will be rated as received until June 30. Full information may be obtained from the United States Civil Service Commission, Washington, D. C.

"The Hebrew Physician" (HaRofeh Ho-Ivree), the only medical journal published outside of Palestine which is written in Hebrew, has just made its inital appearance. The journal is under the editorship of Dr. Moses Einhorn and Dr. A. Goldenstein. It contains articles on general medical subjects and has a special section devoted to new Hebrew medical terminology. The publication office is 286 W. 86th Street, New York City.

THE Spanish edition of the U. S. Pharmacopœia, tenth revision, has recently been published by the Board of Trustees of the U. S. Pharmacopœial Convention and is obtainable from the agent, the International Trade Papers, Incorporated, 2 West 45th Street, New York City, for six dollars. Translation was made by a committee from the University of Havana, with the cooperation of Dr. Jose Guillermo Diaz. The United States Pharmacopœia has been adopted as the official pharmacopœia for the Republic of Cuba and is extensively used throughout Central and South America.

THE Phi Chi fraternity of the State of Indiana, whose membership includes some seven hundred medical graduates, plans on giving a state banquet in Indianapolis, February 25, 1928. Initiation will be held in the afternoon and pledges will behold the symbols of Phi Chi and learn the an-

cient and mysterious secrets. Complete program has not been published though plans for the entire day are nearing completion. The fraternity will have the exclusive privilege of one entire floor of the Lincoln Hotel, Indianapolis, for the day. Many letters have been received from alumni over the state expressing intentions of attending the banquet which promises to be the biggest one ever held.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Winthrop Chemical Co., Inc.

Phanodorn

Change of Agency

Gynergen, formerly distributed by H. A. Metz Laboratories, Inc., New York, is now distributed by Sandoz Chemical Works, Inc., New York. The Council has continued the acceptance of Gynergen under the new distributor.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

December 27, 1927.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held December 19 read, corrected and approved.

The release, "Health Resolutions," read, corrected and approved for publication January 2.

Arrangements were completed for a conference between the committee of the Indiana Tuberculosis Society and the Bureau of Publicity on Monday, January 16. Pamphlets to be used in "The Early Diagnosis" campaign of the National Tuberculosis Association came to the attention of the Bureau. In this campaign the National Tuberculosis Association is stressing the need of periodic health examinations. "Go to Your Doctor Before He Has to Come to You" is the headline for the campaign.

Reprints of editorials appearing in the Salamanca *Republican Press* September, 1927, in regard to the attitude of the Cattaraugus Medical Society toward the Cattaraugus county health demonstrations came to the attention of the Bureau.

Suggestions made at the annual council meeting December 16 concerning the work of the Bureau were discussed. Following one of these suggestions at the Council meeting that an Indiana branch of the American Association for Medical Progress be formed, the secretary was instructed to get details concerning this association for presentation at a future meeting of the Bureau. The suggestion of the editor of The Journal of the Indiana State Medical Association to the effect that releases should not omit the subject of quackery was then considered.

Report received from the Better Business Bureau in regard to the alleged overcharge for use of radium by Dr. T. O. Gasaway.

The Bureau authorized the renewal of the subscription for *Hygeia* for three years starting February, 1928.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 4, 1928.

Wm. N. Wishard, M.D.,
Chairman.
Thos. A. Hendricks,
Secretary.

BUREAU OF PUBLICITY

January 4, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held December 27 read, corrected and approved.

The following bills were approved for payment:

W. K. Stewart Co.	$ 1.30
Bailey Office Supply	15.00
Central Press Clipping Service	5.00
Total	$21.30

A paper recently prepared by the secretary of the State Board of Medical Registration and Examination of an informative nature in regard to the work of the Board was read and approved. The Bureau suggested that a notice be placed in the January number of the Secretary's Bulletin that the secretary of the State Board of Medical Registration and Examination is available for discussion of work of that Board. He may be addressed through this office or directly through his own office at Hammond.

The following letter was received from the secretary of the Knox County Medical Society:

"I wish to thank you for your recent letter offering to aid us in increasing our attendance at our meetings. I think your suggestion that your office send out letters in addition to the regular letter which I send each month is a good one.

"We plan our next meeting to be January 10 and have invited four physicians from adjoining towns in the county to furnish the program. We have suggested that each of them relate several unusual, interesting or amusing experiences which they have encountered in the practice of medicine.

"This is a little out of the ordinary and we are hoping that it will stimulate some interest. We will probably call upon you to furnish a speaker for our February meeting, and at that time will be glad to give your suggestion a trial.

"Thanking you for all past favors, I am."

A request was received from the secretary of the Minnesota State Medical Society for several copies of a pamphlet issued by the Publicity Bureau, entitled "The Indiana State Medical Association and the Executive Secretary."

A letter was received from the physical director of the Y. M. C. A. at Richmond, Indiana, in regard to alleged distribution of Koch "cancer cure" literature at a recent Richmond health meeting by S. Edgar Bond under the name of St. Luke's Hospital. The secretary was instructed to answer this letter calling attention to the fact that the proper channel for all public health work is through the county medical society. The Bureau restated its position that no cooperation whatever was given to any meeting where fake cancer cures and other unapproved fads are exploited. The Bureau has had nothing to do with such a meeting and does not and will not in any way indorse it.

A letter was received from the *Medical Review of Reviews* saying that the editors of this paper would be glad to receive copies of clippings of the recent release, "Cigarette Advertisements," which appeared in the Indiana press.

The secretary was instructed to distribute copies of the monthly secretaries' bulletin to each member of the Publicity Bureau at the meetings.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 9, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

January 9, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held January 4 read, corrected and approved.

The release "Cancer 'Cures'" was further considered and approved for publication on Monday, January 16.

An outline was submitted for a series of articles upon Periodic Health Examinations. This was reviewed and discussed by the committee. This outline will form a basis for several releases upon periodic health examinations.

The flight surgeon with the One Hundred and Thirteenth Observation Squadron of the Indiana National Guard has offered to write an article on "Aviation Medicine." The Bureau expressed itself as being more than pleased to review any article upon this subject either for possible publication in the State Journal or as a release for the newspapers.

A bulletin was received from the Medical Society of the District of Columbia stating that that organization had a Committee on Civic Health which acts as a liaison committee between the various civic organizations and the society. "It shall be the duty to keep the society informed of any proposed activities which may affect in any way the health of the community and the organized profession," the Bulletin states. "From time to time it shall seek the advice of the society on such matters and actively pursue any course according to the instructions of the society." The Bureau of Publicity of the State Association acts in a similar way for the Indiana profession.

A letter was received from the councilor of the first district asking the Bureau to send the secretary of the Warrick County Medical Society all available information on post-graduate study.

Arrangements were completed for a speaker to address a meeting of the North Manchester Parent-Teachers' Association Tuesday evening, January 17.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 16, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

January 16, 1928

Meeting called to order at 4:45 P. M.

Present: Wm. N. Wishard, M.D., Chairman; Murray N. Hadley, M.D., J. A. MacDonald, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held January 9 read, corrected and approved.

"The Committee on Co-operation with the Indiana State Medical Association" from the Indiana Tuberculosis Association, composed of Dr. E. M. Amos, Indianapolis; Dr. F. C. Dilly, Brazil, and Murray A. Auerbach, executive secretary of the Indiana Tuberculosis Association, attended a meeting of the Bureau.

The Chairman of the Publicity Bureau said that the House of Delegates at its meeting in September, 1927, had given authority to the Publicity Bureau to "act as a special committee to confer with similar committees appointed by voluntary health agencies on matters pertaining to the work of these public health organizations and their relation to the medical profession." Therefore the Publicity Bureau had the approval of the House of Delegates to meet and discuss such matters with the representatives of the Indiana Tuberculosis Association.

The representatives of the Indiana Tuberculosis Association said in substance: "The Indiana Tuberculosis Association had appointed them as a special committee to meet with a committee from the Indiana State Medical Association in order that a better understanding and co-operation may be gained between the two organizations. They spoke of the fact that a similar understanding had been reached in New York State. Special reference was made to the opposition of some of the physicians to the clinical work that is being carried on in some sections by the Indiana Tuberculosis Association. Opposition from the profession to this work, the members of the visiting committee thought, was due to a misunderstanding of the work.

A nation-wide "early diagnosis campaign" is to be launched by the National Tuberculosis Association in March. The basis of this campaign is "go to your doctor." Talks, posters, circulars prepared by the National Tuberculosis Association are to be distributed throughout the country through the various county tuberculosis organizations. This campaign was planned to a large extent and in every instance the material was approved by physicians. The campaign is not only to be carried on with the lay public but abtracts are also to be distributed among the physicians. A technical film has been prepared for physicians and will be available for use when called upon by the various county medical societies. There is also a film for the laity. All the circulars that go to the laity have as a final and conclusive statement, "Let your doctor decide."

The National Tuberculosis Association carries on its campaign against tuberculosis in much the same way that the Publicity Bureau carries on its educational campaign against disease.

As a result of the conference the following suggestions were made:

1. The Publicity Bureau is preparing a series of four articles upon periodic health examination. These four articles can be followed very well by one or more articles concerning the "early diagnosis campaign" of the National Tuberculosis Association in March.
2. The Publicity Bureau may suggest a speaker upon the subject of tuberculosis to county societies asking the Bureau to fill a speaking engagement.
3. THE JOURNAL of the Indiana State Medical Association may carry articles and editorials concerning the co-operative effort of the Indiana Tuberculosis Association and the Bureau of Publicity of the Indiana State Medical Association and can tell of the "early diagnosis campaign" of the National Tuberculosis Association.
4. Some member of the Indiana Tuberculosis Association should appear before the Indianapolis Medical Society and read a paper explaining the work of the Tuberculosis Association. This should be done at as early a date as possible.
5. The representative of the Indiana Tuberculosis Association invited the State Association to send a representative to Gary to attend the annual meeting of that Association, February 15 and 16. The Bureau of Publicity was to recommend that the president of the State Asociation appoint such a delegate who was to attend the meeting and make a full report to the State Medical Association through the columns of THE JOURNAL and before the House of Delegates next September.
6. The suggestion was made that a representative or some prominent, nationally known man of the National Tuberculosis Association should appear upon

the Scientific Program of the State Association. A member of the Publicity Bureau moved that such a recommendation be made to the Scientific Program Committee of the State Association. It was suggested that such a man perhaps might speak at the annual banquet which is held during the annual meeting of the Association.

7. It was suggested that the Bureau of Publicity and the special committee of the Indiana Tuberculosis Association sit as a body to discuss and take up any matters of difference which arise between the members of the profession and the members of the Indiana Tuberculosis Association.

The release, "Periodic Health Examination" article No. 1, was read, corrected and approved for publication January 23, 1928.

The secretary was instructed to call the attention of the following organizations to the series of periodic health examination articles:

a. State Board of Health
b. Officers and councilors of State Association
c. Indiana Tuberculosis Society
d. Parent-Teachers Association
e. American Red Cross.

Requests for speakers from the following county societies were received:

January 24, Johnson County Medical Society. Executive Secretary was authorized to accept the invitation to attend the meeting and the Bureau offered its aid in notifying physicians of the county concerning the meeting.

January 25, Tri-County Medical Society, North Vernon. Speaker assigned to talk upon "Upper Respiratory Influences."

January 27, Hendricks County Medical Society. Secretary instructed to obtain speaker.

February 6, Fountain-Warren County Medical Society. Secretary instructed to obtain speaker on subject, "Medical Jurisprudence" or "Practical Legal Medicine."

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 23, 1928.

WILLIAM N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

VANDERBURGH COUNTY MEDICAL SOCIETY

The Vanderburgh County Medical Society met at the Evansville Public Health Center January 10, 1928.

The meeting was called to order by G. C. Johnson, M.D., president. The minutes of the last meeting were read and approved.

Shelby W. Wishart, M.D., presented two cases of heart disease followed by a very interesting talk upon "The Diagnosis and Treatment of Certain Types of Heart Disease." Discussion by Drs. Reitz, Brose, Lorenz, and H. M. Baker.

On the recommendation of the Board of Censors, C. C. Herzer, M.D., was voted a member of the society.

Wm. E. Barnes, M.D., secretary of the Board of Health, presented plans for improving the health of Evansville. These included a contagious disease hospital, better obstetrical care for the poor, and an ambulatory dispensary for the poor. These plans were indorsed by the society.

KEITH T. MEYER, M.D., Secretary.

WOMAN'S AUXILIARY OF THE INDIANA STATE MEDICAL ASSOCIATION

INDIANAPOLIS AUXILIARY

At the regular monthly meeting of the Woman's Auxiliary of the Indianapolis Medical Society, January 6, the officers for 1928 were elected as follows: President, Mrs. David Ross; vice-presidents, Mrs. William S. Tomlin, Mrs. John T. Wheeler, Mrs. Alfred Henry, Mrs. Edgar Kiser; recording secretary, Mrs. Harry L. Foreman; corresponding secretary, Mrs. John Brayton; publicity secretary, Mrs. Ross Ottinger; treasurer, Mrs. D. O. Kearby.

Andrew Elias Soudah, of Acre, Palestine, a senior in the Indiana University School of Medicine, spoke on customs of his native land.

At a luncheon meeting, January 18, Mrs. D. O. Kearby and Mrs. Harry L. Foreman were hostesses to the officers for 1927 and the officers for 1928. Committees were appointed and plans for the coming year discussed.

GENERAL AUXILIARY

On January 7th, the executive board of the Woman's Auxiliary to the American Medical Association held its mid-year meeting at the Stevens Hotel in Chicago. Mrs. John O. McReynolds, of Dallas, Texas, national president, presided, with representatives from many states. The Indiana report was presented by Mrs. F. W. Cregor, of Indianapolis, president of the Woman's Auxiliary of the Indiana State Medical Association.

Mrs. Cregor again urges formation of auxiliaries in all counties; physicians' wives may exercise great influence in their respective clubs.

The Woman's Auxiliary is featuring Hygeia, the health magazine. The cultists and faddists are pushing their own literature onto every possible reading table. To encourage subscriptions to Hygeia, Mrs. J. O. McReynolds offers a prize of fifty dollars to the county, and fifty dollars to the state showing the greatest increase in subscriptions; this to be in proportion to the auxiliary membership.

Attention is called to a handsome magazine offered by the Woman's Auxiliaries of the State of Texas; it gives the history, aims and purposes of the Auxiliary, and contains articles by prominent physicians throughout the United States. Indiana's state editor, Dr. A. E. Bulson, Jr., is one of the contributors. This magazine is available to all who are interested and send in names.

Mrs. Cregor urges, "Ladies, read your state medical journal.' The scientific articles may be skipped, but READ the editorials. They will give you information on many subjects agitating the medical profession, besides supplying you with some knowledge for your discussions in non-medical circles. THE JOURNAL can come to the home from the office.

VIGO COUNTY MEDICAL SOCIETY "ANNUAL" PARTY

Bedecked in long tailed coats and embellished with the facial trimmings that characterized the profession during the "gay nineties" members of the Vigo County Medical Society got together last month for their big annual party and frolic at the Deming Hotel in Terre Haute. Good food, good music, good entertainment and best of all, good fellowship marked the event and hosts and visitors agreed that it was "the best ever."

Dr. John Randolph Gillum, acting as toastmaster gave all the "boys" a good send-off and the formal speaking of the evening got away to a good start with interesting talks by Dr. George T. Johnson, retiring president, and Dr. Otto R. Spigler, president-elect of the society. Honors were about even when it came to oratory but Dr. Spigler scored heavily over his predecessor with his becoming Lew Field's derby.

By a clever arrangement, a regular "Sam and Henry" radio talk was staged, Dr. W. E. Stewart impersonating both Sam and Henry and even supplying a generous amount of static to make the presentation absolutely realistic. This was followed by a most enjoyable series of three minute reminiscenses by "the old timers" among them being Dr. Thomas W. Moorehead and Frank E. Wiedemann, who appeared without disguise, Dr. M. R. Combs who faced his audience with a generous supply of Bolshevik whiskers, Joseph Weinstein, Charlie Combs and Frank H. Jett, whose countenances were arrayed in artistic "soup strainers."

But the climax of the evening came with the ancient and honorable ceremony, unique to Vigo County, the "Crowning the King of the Suckers." This title along

with an ornate and priceless "sky piece" goes to the member of the society who in the mind of the retiring "Kink" has distinguished himself above his colleagues in ways other than scientific during the year. O. O. Alexander, the abdicating monarch made the award for 1928 to Dr. A. M. Mitchell for "his elaborate display of diplomacy and perfect decorum in international affairs together with expert markmanship and conspicuous bravery under fire."

Movie pictures of practically every member of the Vigo County Medical Society taken by Dr. Charley Wyeth with his own camera brought the big party to a close. The committee in charge was composed of Drs. M. R. Combs, H. W. Bopp, Rudolph Duenweg, J. R. Young and D. R. Ulmer.

CORRESPONDENCE

COUNTY MEDICAL SOCIETY SECRETARIES

Lafayette, Ind., Jan. 14, 1928.

Dear County Medical Society Secretary:

Have you sent to THE JOURNAL a complete list of your officers for 1928, and if not, will you please do so at once? Be sure to see that you elect a delegate and an alternate delegate if you did not do so in 1926, and give Tom their names.

Have all of the members of your society paid their 1928 dues, and if not will you make an effort at once to secure dues from the delinquents? Emphasize the reason for the prompt payment of dues, and what it means to the member to be delinquent. If you have physicians in your county who are in active practice and in good standing who are not members of your county medical society, please make an effort to include them in your membership.

Have you any questions to ask regarding the method to be pursued in increasing the membership of any medical society, or suggestions to offer that will be helpful to others? Some county medical society secretaries are very successful and ought to be able to give splendid advice in aiding other secretaries to be equally successful.

Suggestions are needed for getting up better programs for our county medical society meetings, and you may have some advice to offer concerning the method to be pursued to increase interest and attendance. Have you studied carefully the suggested program for county medical societies as given by Dr. F. C. Warnshuis at our annual secretaries' dinner and which program was printed in the October number of THE JOURNAL? The suggestions can be used to good advantage in any county medical society in Indiana.

I want to urge every county medical society secretary as well as the members of his particular society to make use of the special page in THE JOURNAL for asking questions and offering suggestions.

Last, but not least, let us all be boosters and not knockers. Let us all work for a larger and better State Medical Association for 1928.

Sincerely yours,
J. C. BURKLE, M.D.,
Chairman of
Secretaries' Conference.

COMPETITION OF STATE LABORATORIES

Fort Wayne, Ind., Jan. 15, 1928.

Editor of THE JOURNAL:

The competition of the state laboratories is one of the most important problems confronting the clinical pathologist, and it vitally affects his economic status. Likewise, to an alarming extent the state laboratories, in their various activities, are invading the domain of private practice and apparently are headed toward the goal of state or socialistic medicine. The care of indigents or of the inmates of state institutions is without doubt the duty of state and municipal health agencies, but when the state offers gratuitous aid in the diagnosis and treatment of the masses of our population, many of whom would consider it an insult to receive coal or provisions free and yet take state laboratory aid as a matter of course, then the state is encouraging lack of self-respect in its citizens and aiding in the production of dependency and even pauperism. The present situation also offers an ever-present temptation to the unscrupulous physician to use the state laboratories to further his private practice by collecting fees for the free examinations made by the state and diverting them to his own pocket. That this is done extensively by the quacks and by unscrupulous physicians cannot be questioned. Efforts to correct the evil have been attempted in other states and are still in progress. In Michigan the state requires the physician to give the name and address of each patient upon whom a Wassermann is done by the state. When the report is sent to the physician a slip is sent to the patient stating that the work has been done without charge by the state and a report of the result may be obtained from the physician. Such a plan should in a large measure remedy the evil, for if the physician gives a fictitious name, the report will be returned to the state laboratory and then the matter can be taken up with the physician.

It would be very desirable if our own state laboratory would adopt such a system as prevails in Michigan, for at the present time there is great abuse of the state laboratories in Indiana. A year or so ago the State Board of Health promised to adopt some measures to eliminate free laboratory service to those able to pay, but it is very evident that the plan was rather haphazardly adopted and never has been a success. Isn't it time for physicians as a whole to enter a protest concerning an abuse that has a tendency to eliminate individual effort and is a long step in the direction of state or socialistic medicine? Our State Medical Association has attacked the abuse of free diagnostic and hospital service by our state hospitals, so why not oppose free laboratory service by the state laboratories?

Respectfully,
B. W. RHAMY, M.D.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

ANÆROBIC ANTITOXIN.—An antitoxic serum prepared by immunizing animals against the anærobic bacteria found in gangrenous wounds. Evidence has been published to indicate that the use of anærobic toxin preparations may be of value in the treatment of gas gangrene.

ANÆROBIC ANTITOXIN (POLYVALENT) — LEDERLE.—An antitoxic serum prepared by immunizing horses with gradually increasing doses of B. tetani and of B. welchii and Vibrion septique, both obtained from anærobic broth cultures of the organisms. Potency tests for the content of tetanus antitoxin and B. welchii (perfringens) antitoxin are made according to the methods prescribed by the U. S. Hygienic Laboratory; for determining the strength of the Vibrion septique antitoxin, serial dilutions of the antitoxin are mixed with Vibrion septique toxin and the mixtures injected into rabbits. The product is marketed in 100 cc. vials, each cubic centimeter containing 50 units of tetanus antitoxin, 2 units of perfringens (B. welchii) antitoxin, and sufficient Vibrion septique antitoxin to neutralize one thousand M.L.D. of the Vibrion septique toxin. Lederle Antitoxin Laboratories, New York.

AMPULS DEXTROSE (d-Glucose) 10 Gm., 20 cc.—Each ampule contains Dextrose, U.S.P., 10 Gm.; cresol, 0.1 percent; distilled water to make 20 cc.; buffered with dibasic sodium phosphate anhydrous and potassium biphosphate anhydrous. H. K. Mulford Co., Philadelphia.

AMPULS DEXTROSE (d-Glucose) 25 Gm., 50 cc.—Each ampule contains Dextrose, U.S.P., 25 Gm.; cresol, 0.1 percent; distilled water to make 50 cc.; buffered with dibasic sodium phosphate anhydrous and potassium biphosphate anhydrous H. K. Mulford Co., Philadelphia. (Jour. A. M. A., December 10, 1927, p. 2041).

Insulin-Squibb, 100 Units, 10 cc.—Each cc. contains 100 units of insulin-Squibb (New and Nonofficial Remedies, 1927, p. 197). E. R. Squibb & Sons, New York.

Staphylococcus Mixed Bacterin.—A staphylococcus vaccine (New and Nonofficial Remedies, 1927, p. 363), each cc. containing 4,000 million killed *Staphylococcus albus and Staphylococcus aureus* in equal proportions. It is marketed in 5 cc. vial packages; in single 20 cc. vial packages; and in packages of six 1 cc. ampules. Abbott Laboratories, North Chicago, Ill.

Erythrol Tetranitrate Tablets-Merck, ¼ Grain.—Each tablet contains ¼ grain of erythtol tetranitrate (New and Nonofficial Remedies, 1927, p. 267). Merck & Co., Inc., Rahway, N. J.—(*Jour. A. M. A.*, December 24, 1927, p. 2193).

Typhoid Prophylactic.—This typhoid vaccine (New and Nonofficial Remedies, 1927, p. 366) is also marketed in 5 cc. vials containing 1 billion killed typhoid bacilli per cc.and 20 cc. vials containing 1 billion killed typhoid bacilli per cc. Abbott Laboratories, North Chicago, Ill. (*Jour. A.M.A.*, December 31, 1927, p. 2263).

PROPAGANDA FOR REFORM

Magic Materia Medica.—This is put on the market by one C. E. Krueger. He claims to be a chemist and states that, so far, he has "not been able to learn what this healing substance is," but emphasizes that his preparation contains just enough radium to be effective. Mr. Krueger has high and lofty ideas regarding its therapeutic value. He claims that Magic Materia Medica has "cured cataract," is "an excellent eye wash," is good for catarrh and hay-fever, and has cured rheumatism, neuralgia, lumbago, eczema, diphtheria, pleurisy, goiter, boils, pimples, stomach, intestinal and kidney trouble, and is even claimed to cure cancer. The A. M. A. Chemical Laboratory reports that from analysis it is concluded that "Magic Materia Medica" is essentially a 10 percent solution of a mixture of approximately equal weights of anhydrous calcium nitrate and anhydrous calcium chloride, plus a very small amount of sodium iodide.—(*Jour. A. M. A.*, December 3, 1927, p. 1983).

The Viavi Fake.—For years there has been exploited throughout the United States a piece of quackery known as "Viavi." The business was founded by two brothers, Messrs. H. and H. E. Law, San Francisco. Viavi is not the name of a single preparation; it is a generic name given to a long list of nostrums put out by the Viavi Company. Practically all of the preparations are sold for the alleged alleviation and cure of diseases peculiar to women. The basis of most of the Viavi preparations seems to be golden seal. Some years ago the *California State Journal of Medicine* published a detailed expose' of the Viavi quackery. In general Viavi had not been advertised to any extent in newspapers. However, immediately Viavi advertisements appeared in all the San Francisco papers and no further newspaper criticism appeared. A physician reports the case of a woman with unmistakable evidence of cervical carcinoma of several months' standing. The history of the case was that the young woman, some four months previously, instead of going to the family physician, fell into the hands of the local Viavi agent. Finally the Viavi people told the woman she had cancer and recommended that the sufferer go to Detroit and take the Koch treatment! Before the poor woman could decide what to do, the lesion ulcerated into an artery. The family physician writes: "Four months ago there might have been a chance to save the life of this young mother; today, the case is practically hopeless."—(*Jour. A. M. A.*, December 3, 1927, p. 1983).

Monahato Another Lead and Sulphur Hair Dye.—"Monahato" is put on the market by the Moulton Products Co., Lombard, Ill. It is described as the "original, natural hair tonic." Contrary to the claims on the package, Monahato is *not* a "natural hair tonic"; it is *not* "a genuine herb compound," and it *does* "rely upon harmful chemicals" for the property it has of dyeing the hair. Although the carton declares, by inference, that Monahato contains no lead salts or sulphur, analysis of the preparation in the A. M. A. Chemical Laboratory disclosed the fact that it contains both. In other words, Monahato is essentially a hair dye of the lead-salts and sulphur type.—(*Jour. A. M. A.*, December 10, 1927, p. 2059).

Miracle Pyorrhea Powder.—"Let us save your teeth! We can do it! No matter how soft or how spongy and bleeding the gums may be, or the teeth so loose it seems you could pick them out with the fingers, the Miracle Pyorrhea Powder will make them hard and firm again." These were some of the claims made by the Miracle Remedy Co. of Detroit for its product, "Miracle Pyorrhea Powder." Analysis seems to show that the preparation is essentially a mixture of baking soda and borax, or possibly boric acid, to which has been added a very small amount of aromatic oil. Some miracle!—(*Jour. A. M. A.*, December 10, 1927, p. 2059).

Golden Glint.—If we are to believe the advertising material that comes with the trade package, Golden Glint (J. W. Kobi Co., Seattle, Washington) "is a specialist's preparation for harmlessly beautifying the hair." There is also a "Golden Glint Shampoo." From an examination made in the A. M. A. Chemical Laboratory it appears that Golden Glint is essentially a mixture of aniline dyes, such as methyl violet (used in indelible pencils) and Bismarck brown, with excipients.—(*Jour. A. M. A.*, December 10, 1927, p. 2059).

Knox-Tartar.—This is a preparation of A. W. Knox, Los Angeles, sold for cleaning the teeth. The carton declares that the product contains "no acid" and "no pumice." From an examination made in the A. M. A. Chemical Laboratory, the product appears to be essentially an abrasive (kieselguhr) to which has been added a very small amount of starch.—(*Jour. A. M. A.*, December 10, 1927, p. 2059).

Poliomyelitis Antistreptococcus Serum. — In cases of epidemic poliomyelitis that come under treatment after the paralysis is well established, the best that can be done is to give as good general medical and nursing care as possible. Cases have been described in which convalescent serum—serum from patients who have recovered from the acute symptoms of the disease—appears to have prevented the development of paralysis. The use of Rosenow's poliomyelitis antistreptococcus serum can be justified only as an experiment. The claims of Eli Lilly & Co. to the contrary notwithstanding, this serum so far has not been accepted as of such value as to warrant its general use.—(*Jour. A. M. A.*, December 10, 1927, p. 2061).

The Rectal Administration of Ether and Oil.—The Council on Pharmacy and Chemistry has authorized publication of a report prepared by R. A. Hatcher on the Gwathmey Method of Anesthesia, concerning the rectal administration of ether and oil. Dr. Hatcher summarizes his report in part thus: The admixture of ether with oil or liquid petrolatum constitutes an advance over other methods for the rectal or colonic administration of ether. Probably a mixture of equal volumes of ether and olive oil (or liquid petrolatum) is the most suitable for inducing anesthesia by rectal instillation after the subcutaneous injection of morphine. The method has certain advantages and also certain disadvantages. It shares with anesthesia by inhalation certain drawbacks. There is an urgent need of detailed statistical studies of accidents due to anesthesia conducted in various ways. The choice of an anesthetic and its mode of administration should be made with the same care with which one chooses other therapeutic agents in the treatment of disease, and the use of any method as a routine is irrational and dangerous.—(*Jour. A. M. A.*, December 17, 1927, p. 2114).

Progress in Obstetric Anesthesia and Analgesia.—For almost fifteen years, the method of Gwathmey, involving the rectal administration of ether and oil for

anesthesia, has been before the profession. More recently the method has been combined with the subcutaneous injection of magnesium sulphate, particularly for use in obstetrics. Varying reports have appeared in medical literature as to the value of these procedures under such conditions as are encountered in the clinic, in the hospital and in private practice. It seemed desirable, therefore, for the Council on Pharmacy and Chemistry to prepare a statement of the present status of these methods. A survey of the literature indicates to Dr. Robert A. Hatcher that rectal or colonic oil-ether anesthesia has the advantages of sparing the respiratory passages, decreasing secretion in the respiratory tract, eliminating or alleviating the stage of excitement, lessening nausea and leaving clear the field for operations about the head and face. On the other hand, this manner of producing anesthesia is not under such perfect control as when anesthetics are given by the inhalation method. The chief use of the synergistic method of Gwathmey has been in relieving the pains of delivery. The time is not ripe for such general and indiscriminate use of the method as will unfailingly be encouraged by commercial exploitation which has already been done.—(*Jour. A. M. A.*, December 17, 1927, p. 2118).

OXYGEN BY INJECTION.—Experiments to determine the value of administering oxygen intravenously, intraperitoneally and subcutaneously on dogs are reported. Theoretically the oxygen tension of arterial blood can be raised by intravenous injection of oxygen. Practically, however, the oxygen deficiency is accentuated when this point is reached. Results from subcutaneous injection were even less encouraging. There was, however, sufficient absorption from intraperitoneal injection of oxygen to justify clinical experiment with the method. It would be necessary to control the procedure by arterial puncture and blood-gas analysis.—(*Jour. A. M. A.*, December 17, 1927, p. 2120).

PUL-BRO-TU, A PORTLAND FAKE CONSUMPTION CURE.—Newspapers and magazines all over the country are receiving a three-page typewritten communication on the stationery of the mayor's office at Portland. The letter is addressed to the council of the city of Portland, and it purports to be a final report relative to tuberculosis tests said to have been conducted by the board of health of Portland, in conjunction with other agencies and individuals, with a product put out by one George Kirkpatrick. While the tests were carried out on cows, the mayor states that "the medical fraternity should take immediate steps to apply the treatment through the medium of painstaking tests to the human family." Kirkpatrick is not a physician. He has been arrested at various times for violation of the Medical Practice Act. The preparation "Pul-Bro-Tu" has been on the market, it seems, for seventeen years, but it is only since Kirkpatrick received political backing that he has made any large noise in the field of quackery. The preparation was analyzed in the A. M. A. Chemical Laboratory in 1926, and was found to be a weak solution of potassium iodide and Fowler's solution. The nostrum has not the slightest value as a cure for tuberculosis; on the contrary, the danger of administering iodides to the tuberculous is well known.—(*Jour. A. M. A.*, December 17, 1927, p. 2121).

YOUTHRAY, ANOTHER LEAD AND SULPHUR HAIR DYE.—"Youthray," which, according to the label, "restores your youthful natural color to gray hair" and is "not a dye," is put on the market by the Ray Laboratories, Chicago. A booklet declares that "Youthray is entirely harmless" and is "unusually effective for ending dandruff" and for "promoting scalp and hair health." The A. M. A. Chemical Laboratory analyzed the preparation and reports that it belongs to the lead acetate and sulphur type of hair dye. While cosmetics do not come under the control of any federal law, the claims regarding dandruff and "hair health" and similar claims should bring the preparation within the jurisdiction of the federal authorities.—(*Jour. A. M. A.*, December 17, 1927, p. 2133).

RICINOLEATED SCARLET FEVER TOXIN.—Unofficial reports indicate that the ricinoleated toxin has not protected effectively against scarlet fever in several institutions in which it was given. Theoretically it hardly seems possible that a single dose would establish a lasting immunity, and it is hardly to be expected that the addition of a "detoxifying" agent will increase the immunizing properties of a toxin. Ricinoleated toxin does not appear to be as reliable as the five doses of the Dick toxin.—(*Jour. A. M. A.*, December 17, 1927, p. 2135).

SO-CALLED SYNERGISTIC ANALGESIA.—The Council on Pharmacy and Chemistry has authorized publication of a report prepared by R. A. Hatcher on the Gwathmey Method of Anesthesia, concerning so-called synergistic analgesia. The report states that a final opinion on the synergistic action of ether in oil with magnesium sulphate requires a much more accurate knowledge than now exists concerning the potentiation in anesthetic and analgesic action and the lack of potentiation in the toxic actions such as Gwathmey claims to have found. The evidence for his claims is not convincing. It seems quite possible, however, that magnesium sulphate has some action that may be utilized to advantage in anesthesia when our knowledge of its mode of action with morphine and ether is much greater than it is at present.—(*Jour. A. M. A.*, December 24, 1927, p. 2189).

THE HEALTH ANGLE IN ADVERTISING.—The physician has become a prophet in the land, and health is the word with which one conjures. Regardless of the substance to be advertised, the agency goes forth in search of medical opinion with which to vaunt it. A soup is sold with the claim, "There is health in every spoonful." Of certain toilet accessories it is said, "Your doctor will advise against harsh, rough papers." Certified milk is called "health bottled in bond." And so it goes. The doctor's advice has been sought, it seems, for many of the most mundane affairs of human existence. The difficulty of evaluating advertising copy in these modern times is an evidence of the changing situation. The modern agency supports by evidence the claims for the products promoted. The presentation of such evidence often seems an exaggeration of conditions as they are, yet the evidence is almost invariably actual. No doubt physicians have been too ready to accept broad generalizations in the field of hygiene. They seldom require the same kind of evidence in support of a cleansing agent, a dietary product or tobacco that they would demand in support of a new remedy. Hence the promoters are easily able to secure the necessary number of medical endorsemnts. Fortunately the situation may take care of itself; the overdoing is certain to result in reaction. But if the great minds in the advertising agencies are wise they will begin to reconsider now. Otherwise the good is likely to be lost with the evil.—(*Jour. A. M. A.*, December 24, 1927, p. 2195).

ANALGESIA IN CHILDBIRTH.—The Council on Pharmacy and Chemistry has authorized publication of a report prepared by R. A. Hatcher on the Gwathmey Method of Anesthesia, concerning analgesia in childbirth. The available evidence indicates that the use of morphine during the first stage of labor and ether or chloroform for the second stage appears to be the accepted procedure and that morphine with chloroform appears to present special dangers. With proper precautions morphine sulphate in the dose of 0.01 Gm. (one-sixth grain) for a woman of average size, is virtually without danger. The report concludes that no method of inducing analgesia is suitable for universal use. So-called painless childbirth is frequently a most difficult problem. The general practitioner is often misled into believing that he can secure better results by the method that he reads about than by the methods with which he is familiar, when in truth it presents no essential advantage, and, on the contrary, it will prove inferior in his own hands to that with which he has acquired a certain degree of skill. In

(Continued on adv. p. xx)

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TRUTH ABOUT MEDICINES

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view of this, the commercial exploitation of proprietary products based on the Gwathmey formulas is potent for much harm, since it will inevitably tend to promote the thoughtless and ill-advised use of the method.—(*Jour. A. M. A.*, December 31, 1927, p. 2258).

BOOK REVIEWS

TRANSFUSION OF BLOOD, by Henry M. Feinblatt, M.D., Assistant Clinical Professor of Medicine, the Long Island College Hospital, Brooklyn, N. Y.: Hematologist to the United Israel-Zion Hospital: Pathologist to St. Peter's Hospital: Assistant attending physician to the King's County Hospital: Hematologist to the Shore Road Hospital. Author of "Clinical Laboratory Medicine." 137 pages, illustrated by 24 engravings. New York., The Macmillan Co., 1926.

This brochure presents a critical survey of the subject of blood transfusion, and is so arranged that it should be valuable as a ready reference work on this subject. The various methods of blood transfusion are given, including the author's method in clear cut manner. The chapter on blood grouping is especially complete and clear.

PRINCIPLES OF CHEMISTRY, an introductory textbook of inorganic, organic and physiological chemistry for nurses and students of home economics and applied chemistry, with laboratory experiments. By Joseph H. Roe, Ph.D. Professor of chemistry, George Washington University Medical School; Lecturer in chemistry, Central School of Nursing, Washington, D.C.; Captain Sanitary Division, U. S. Medical Reserve, 378 pages with illustrations. St. Louis. The C. V. Mosby Co., 1927, price $2.50

This book has been written to meet the requirements of the National League of Nursing Education for 45 to 65 hour courses. Special efforts have been made to use simple language in treating with the applications of chemistry to biology, medicine, and the arts. Included are a set of laboratory experiments suitable for student nurses including some along the lines of physiological chemistry.

SURGERY, ITS PRINCIPLES AND PRACTICE FOR STUDENTS AND PRACTITIONERS, by Astley Paston Cooper Ashhurst, A.B., M.D., F.A.C.S. Professor of Clinical Surgery in the University of Pennsylvania; Surgeon to the Episcopal Hospital and to the Philadelphia Orthopaedic Hospital and Infirmary for Nervous Disease; Colonel Medical Reserve Corp, U. S. Army, Third edition thoroughly revised with 15 colored plates and 1046 illustrations mostly in the original. Lea and Febiger, Philadelphia, 1927. Price $10.00.

The first edition of this excellent textbook was exhaustively reviewed in THE JOURNAL. This third edition is a distinct improvement over its predecessors. The author has managed by careful editing to incorporate much new matter without increasing the size of his book About 100 new illustrations and two new colored plates have been introduced. The sections on fractures of the femur and of the leg and ankle have been rewritten and are now valuable sections of the book. Among the new subjects considered are granuloma inguinale, massive collapse of the lung and tularemia. The reviewer would suggest that the sections devoted to syphilis and surgery of the female genitals be deleted and that the space thus gained be devoted to such practical subjects as infections of the hand and the treatment of shocks and hemorrhage. It is notable that 48 pages are used in an inadequate presentation of gynecological conditions while blood transfusion is not even mentioned in the index.

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ORIGINAL ARTICLES

NASAL ACCESSORY SINUSES AND THE GENERAL PRACTITIONER*

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CINCINNATI, OHIO

The practice of any of the specialities in medicine gives the specialist an unusual opportunity to observe many symptoms which the busy general practitioner with a larger field for work, entirely overlooks. I know of no special field in medicine which is more often neglected, and which receives as little attention by the general practitioner as that of diseases of the nasal accessory sinuses. The reason for this is quite obvious. Few physicians ever have learned to make a systematic rhinoscopic examination. There are not many who know that hyperplastic ethmoiditis is a frequent disease and is many times the cause of chronic headache, and that a bronchitis which will not yield to treatment often subsides in a few days after irrigation of an infected antrum. Furthermore, that a patient with chronic gastro-intestinal symptoms often is relieved after the cessation of a post-nasal purulent discharge, and that a secondary anaemia is not corrected until the toxemia resulting from a nasal accessory sinus disease is in abeyance. It hardly seems justifiable that a patient with chronic laryngitis and bronchitis should be treated for six months for tuberculosis when the infection in the lower respiratory tract is only secondary to a suppuration in the sphenoid cavity, radical treatment of which brings relief of the hoarseness and cough. So much for the short-comings of the general practitioner.

The rhinologist as well has been lax in his method of studying the nasal accessory sinus problem. He has, as a rule, looked upon the condition as merely a local affair, and ignored entirely the fact that many cases of nasal accessory sinus disease are the result of some constitutional derangement, as for instance, intestinal toxemia, gout, syphilis, gall-bladder disease, endocrine disturbances, etc. Furthermore, the rhinologist has very often arrived at a diagnosis regarding the nasal accessory sinus disease without careful and repeated examinations of the nose; and lastly, he has in many instances neglected to ascertain the character of the infection and has operated upon the nose in the presence of a streptococcus hemolytic infection, which procedure may be followed by serious complications. There are many patients who are constantly complaining of cold in the head, and upon whom many operations have been performed without success. We must not overlook the fact that a constitutional disturbance is probably the cause. Patients who take little exercise, who eat plentifully, and who are constipated, will very often be frequent sufferers of a vaso-motor disturbance in the nose, which simulates a nasal accessory sinus disease. The rhinologist may have displayed good judgment in correcting a deviation of the nasal septum, and removing mild hyperplasia from the ethmoid cells, but unless he considers the constitutional factor in many instances he will not get satisfactory results.

Many patients present themselves to the rhinologist suffering with headache. The rhinologist examines the patient and finds that there is present a mild hyperplastic ethmoiditis. The middle turbinate is infracted and the hyperplasia of the ethmoid removed, with the preservation of the middle tubinate. After the operation the headache continues as before. The patient becomes discouraged and goes from one doctor to another, until finally someone, probably an internist, makes a careful examination of the muscles of the neck and finds that the patient has a latent arthritis of the sterno-clavicular joint. There is pain on pressure over the joint, and the muscles attached to this area have become hypertonic, and the hypertonicity of the muscles is the cause of the headache, in view of the fact that the occipital nerve in its course through the sterno-cleido mastoid muscle becomes irritated and occipital headache results. It is important for the general practitioner, as well as the rhinologist, in examining a patient with headache, to make careful palpation of the muscles of the neck. The painful spots are usually in the occipital region, and along the central portion of the sterno-cleido mastoid muscle, over the sterno-clavicular joint, and along the course of the trapezius muscle. These patients

*Presented before the annual session of the Indiana State Medical Association, September, 1927.

are not relieved by surgery alone, except occasionally if the focus of infection is in the tonsils or teeth. In most instances these patients need careful massage of the muscles after the operation. Furthermore, a mild ethmoiditis should not be operated upon until all other factors which are the cause of headache, such as impacted third molars, have been excluded.

What is the cause of a sinus infection? It is usually the result of some local disturbance, whether it be a deflected septum, a middle turbinate placed laterally, hypertrophy of the inferior turbinate — anything which may prevent proper ventilation and drainage in a patient suffering with an acute nasal infection. I believe that most colds do not start in the nose but in the pharynx, and that there is something about the consitutional idiosyncrasy of some people which makes them prone to infections. If you have an infection in the pharynx, it does not take long for this infection to travel up into the nose, then into the sinuses, or down into the tracheo-bronchial tree.

Whenever you have a dysfunction of the immunity system you are liable to have frequent infections. If it were not for immunity most doctors would be dead in two years. They could not throw off all the infection to which they are constantly exposed. At St. Moritz, in Switzerland, there is prevalent a streptococcus sore throat which usually attacks two-thirds of the people when they come up from sea level. This is probably caused by endemic weather changes, which transform the normal streptococci in the throat to the hemolytic variety when people reach the higher altitude. If they do not come immediately from sea level, but gradually climb the mountains, this infection does not take place. Furthermore, you all probably have had the experience of having a patient go to Atlantic City after having had a cold for some time and after a few days at the seashore the infection disappears. Whereas, the patient getting the infection at Atlantic City, does not get relief, as a rule, until two or three weeks have elapsed.

A systemic involvement from a focus of infection in the nasal accessory sinuses may occur from —1st: Metastasis, by way of the lymph or blood; 2nd: Infection by way of ingestion; 3rd: Along the lower respiratory tract; 4th: As a result of a toxemia.

I believe that as far as frequency of involvement of the various sinuses is concerned, that the ethmoid is more often involved than any of the other sinuses, with the antrum running a close second. I have never seen a case of so-called "influenza," which is probably nothing more than a streptococcus infection in the nose, which did not show evidence of nasal sinus involvement. It is important that the general practitioner should recognize this fact, because we, as specialists, do not see the cases of influenza except in their convalescence. The general practitioner must, therefore, remember that patients with a low-grade fever and malaise, following an influenza, require a careful examination of the nasal sinuses.

Now, I wish to say a few words concerning the various sinuses. First, the antrum. The pus coming from the antrum in an acute stage is usually of a canary yellow color, and is found between the middle turbinate and the lateral wall of the nose, and also on the floor of the nose. It is large in quantity, and very often is expelled two or three times a day instead of a constant discharge. Many patients with acute and chronic antrum disease never have a discharge anteriorly, the secretions instead flowing post-nasally into the pharynx. This can be accounted for in view of the fact that thirty-three per cent of skulls have a large accessory opening, situated posteriorly, which allows for posterior drainage. The pain from antrum disease is important to consider, because it varies in its location. Very rarely do we have pain in the region of the antrum except in severe cases. Most of the pain is supra-orbital, and therefore we very often have patients referred to us with supra-orbital pain, in whom a diagnosis of frontal sinus infection has been made by the general practitioner. Some patients have pain in the teeth in others the pain radiates toward the ear.

Latent antrum disease is often overlooked, because patients with this disease do not complain of symptoms referable to the nose, and nasal examination is usually negative. These patients very often have a chronic toxemia with occasional colds. When a latent antrum disease is suspected, Lipiodol injections into the antrum should be made in order to exclude the presence of a hyperplasia. Secretions in the nose which originate in the antrum usually are present only in the morning hours. It is therefore advisable, in doubtful cases, to make a careful nasal examination at this time.

It is not always a simple matter in purulent conditions of the nasal sinuses to state definitely where the pus present in the nose originates. If we see pus between the middle turbinate and lateral wall of the nose the definite thing to establish first is whether the antrum is diseased, and if it is affected, is it primarily involved, or is it only acting as a reservoir for the pus from above. Our method of procedure in these cases is to irrigate the antrum, and if the irrigating fluid is cloudy, we pack the nose with a pledget of cotton, in the region of the naso-frontal duct and anterior ethmoid cells, immediately after the lavage of the antrum. This is done in order to prevent the pus from above from entering the antrum. The cotton pledget is allowed to remain from four to six hours. If the irrigation of the antrum after four or six hours shows a clear fluid, we can be reasonably certain that the antrum is acting as a reservoir for the pus from above, and that it is not

primarily affected. If the irrigating fluid is turbid, it is almost certain that the antrum is primarily involved. If the pledget of cotton shows the presence of pus, and the antrum fluid is also cloudy, we are probably dealing with a pan sinusitis. If the antrum fluid is clear, and the cotton saturated with pus, the cells in the ethmo-frontal region are involved. If there is no pus to be seen on the cotton, and the antrum fluid again shows pus at the second irrigation, we are undoubtedly dealing with a primary antrum disease, without ethmoid involvement. A small pledget of cotton allowed to remain in the olfactory fissure for six hours will give some information regarding the posterior ethmoid and sphenoid cavities. The above is an important part of the rhinological examination, and the operative procedure is often dependent on the outcome of these tests.

The teeth are very often a causative factor in antrum disease. Some authorities claim that the teeth are responsible for twenty-two per cent of infected antra; others believe that at least thirty per cent of infected antra are of dental origin. It is not necessary in order to have antrum infection occur as a result of an infection in or about the teeth to have the disease spread by continuity of tissue; neither is it necessary to have a marked disease of the alveolar process in order to affect the antum. Sappey has shown that infections drain from the teeth into the antrum without any involvement of the periapical structure, and that a pulpitis, because of the communication of the lymphatics in this region, with the cavity of the antrum, may be the cause of an antrum infection.

The anatomical variations of the ethmoid sinus is an interesting problem. The cells are very often displaced laterally, and do not always occupy a midline position. We sometimes wish they did. These cells which occupy a central position are easily reached, but those displaced laterally or with a prolongation upward into the frontal, are not easy of access with intra-nasal surgery. We are never certain that we are entering the frontal sinus with the sound, while doing an intra-nasal frontal sinus operation, for the sound may be entering instead an upward displaced ethmoid cell. A case operated upon a few days ago showed this abnormality. The patient had undergone two intra-nasal operations, but was not relieved. Finally, we decided to do an external frontal sinus operation. We opened what we thought was the frontal sinus, but instead found a large bulla frontalis, in other words, an upward displaced ethmoid cell which completely closed the naso-frontal duct. We thought we were going into the frontal sinus at the time of the intra-nasal operations, and it was only through the external operation that we could see that the probe was entering a displaced ethmoid cell. You therefore do not have to have a diseased sinus present in order to have headaches. You may have many abnormal anatomical variations that will cause closure of the naso-frontal duct, and in that way be the cause of headache.

Let me also impress upon you in this connection that hyperplastic ethmoiditis is a very common condition and should be thought of by the general practitioner. These patients usually have a watery discharge from the nose, with little or no pus, except during an acute exacerbation. They often suffer with incessant headaches.

Acute sphenoid disease is rather frequent. It is not usually diagnosed because we do not examine with the naso-pharyngoscope in every case of nasal suppuration. Patients with acute infections of the sphenoid sinus suffer terrific pains around the eyes, in the parietal region, and in the occiput. The application of twenty per cent cocaine solution to the anterior wall of the sphenoid, and occasionally to the posterior wall with irrigation of the sphenoid cavity with 1:10,000 Metaphen solution usually gives relief. In many cases where relief does not take place, surgery may have to be resorted to, when the acute symptoms have subsided.

Fortunately for us, the frontal sinuses are not often affected. In the largest clinics in Europe, where they have about seven thousand new patients a year, they only find it necessary to do an external frontal sinus operation about six or seven times during the year. The difficulty in this operation is to keep the naso-frontal duct patent after operation. We have been more successful in keeping this duct open since using the nasal mucous membrane flaps, placing one flap upward towards the frontal, and another downward into the orbit, with the addition of mucous membrane transplants taken from the lower lip and placed along the bony edge.

It is a matter of common knowledge that nasal accessory sinus disease is the cause of lower respiratory infections. If you look into the pharynx in many cases of sinus disease you often see present a lateral pharyngitis, i. e. a thick mass of lymphoid tissue on the lateral wall of the pharynx. This same thickening of the mucous membrane, to a lesser degree, occurs in the lower respiratory tract, and if such is the case these patients upon the least exposure readily develop a bronchitis, a bronchiectasis, or asthma.

Complications along the alimentary canal may result from the swallowing of pus. It is an interesting observation to note that many patients with antrum infection very often have a co-existing mucous colitis, and, furthermore, that appendicitis is very often a complication of nasal sinus disease. The anatomist, Peter, has termed the appendix "the intestinal tonsil," and because of the vulnerability of the tissues of the appendix to infection, he believes, with others, that infection of

the appendix does not result from the ingestion of pus but from a generalized infection.

Chronic toxemia from nasal sinus disease is a frequent occurrence. The toxemia may cause changes in the blood, the nervous system and the endocrine system. As far as the blood is concerned, little need be said except that many of these cases have a secondary anaemia. Much has been written about insanity being caused by nasal sinus disease. I am not convinced that it is just the pus in the nose that is causing the disturbance to the nervous system. One patient may have an infection of the nasal sinuses, and the only symptom of which he complains is a feeling of malaise. Whereas, another patient may have the same character of infection and become maniacal. There must be an hereditary predisposition or something that we know little about that is the cause of the insanity. An unbalanced nervous system may be caused by an irritant other than the toxins originating from a focus of infection. A patient may have an error of metabolism with a rapid pulse and high blood pressure. Alkalinize this patient and very often the mental disease miraculously disappears. In another case the increased amount of secretion from endocrine glands may be so irritating as to cause the patient to become insane. It is a known fact that insane patients may be brought into a maniacal state by giving large doses of thyroid. So that I am not convinced that infections of the nasal accessory sinuses are very often the cause of insanity. I think there are many other factors in this obscure picture that need be considered.

Chronic infection of any kind, whether from tonsils, teeth, nasal sinuses, or gall bladder, will always in time affect, to some extent at least, the endocrine glands. It is even claimed by Leonard Williams that hypo-thyroidism for example is of frequent occurrence in children, and that it is very often not diagnosed. We do know that patients with a low metabolic rate, with low blood pressure, will not recuperate after an operation unless they are given thyroid substance, and that as soon as the metabolic rate goes up, and the blood pressure is raised, the patient feels better. It is not generally known that infection of the nasal sinuses may be the cause of a thyroiditis by infecting the small glands surrounding the capsule of the thyroid gland, with the formation of adhesions and subsequent co-lateral oedema of the thyroid, which causes inflammatory changes in this gland. Another important fact for the general practitioner to remember is that general sepsis may occur after too much treatment of the nose, when there is present an acute infection. Four cases of death are reported by Siebenman's Clinic, at Basle, as the result of irrigation of the antrum through the natural orifice, in acute antrum disease. My plea is, therefore, never to use too much local treatment in acute infections of the nasal sinuses. Give nature a chance.

Much has been written recently about nasal sinus disease in children. To me the salient points regarding this are; first, do not rely too much on your x-ray findings, because the bones of the child's skull are spongeous, and may show opacity upon x-ray examination without there being present a sinus disease. Second, never operate on a child for tonsils and adenoid tissue in whom there is present a purulent nasal discharge without first taking into consideration the nasal sinuses. If the tonsils and adenoid tissue are removed without taking this into consideration you may be disappointed in your ultimate results. I have seen many of these cases that continue to have a nasal discharge after the tonsils and adenoid tissue are removed, and in whom the nasal sinuses, especially the antrum, should have been given the attention they deserved at the time of the tonsillectomy. Nasal discharge in young children does not always originate in the sinuses. It may come from the mucous membrane, or from the adenoid tissue itself. Many infants have what we call "posterior rhinitis," with purulent nasal discharge. In these patients there is an infection of the mucous membrane on the floor of the nose, in its posterior portion, at which place the mucous membrane often contains numerous folds which readily harbor an infection and simulates a nasal sinus disease.

I wish to say a word concerning the skiagram of the nasal accessory sinuses. The x-ray picture should not be taken too much into consideration, and should only be an adjunct in arriving at a diagnosis. The clinical picture is of more importance. If there is no clinical evidence of disease in the nose repeated examinations are necessary, for it often happens that a latent disease of the antrum or ethmoid is present in which there is no pathological change to be found in the nose. If the antrum, for instance, shows cloudiness upon x-ray examination, and if, after the instillation of lipiodol into the antrum cavity you can clearly demonstrate the fact that a part of the antrum cavity remains unfilled by the lipiodol, then we can be reasonably certain that there is present in this cavity hyperplastic tissue, which may be the cause of recurrent infections.

The presence of polypi in the nose should always make us suspicious of the presence of polypoid changes in the antrum, if the x-ray shows a cloudiness of this cavity. Furthermore, if polypi are present in the nose, and the skiagram of the antrum is clear, we must not be misled, for it often happens that the antrum contains hyperplasia in its recesses which if not recognized may be the means of later on causing the production of nasal polypi. We must always remember to give sufficient time in examining doubtful cases of nasal sinus disease before arriving at a definite

diagnosis, and not to rely too much on the skiagram as an aid.

Now, what should the general practitioner know of the treatment of infections of the nasal accessory sinuses? Relating to prophylaxis, I think the words of James T. Whitaker, my former teacher of internal medicine, are apropos. In his last lecture before our class on the subject of neurasthenia, he said, "in the treatment of this disease, all that is necessary is beams of sunshine, and oceans of fresh air." Exercises in the open, in a person who has no obstruction to nasal respiration and ventilation, will many times do away with any dysfunction of the immunity system, and readily bring into action the defensive forces of the body. It is our manner of living which is responsible for most of the infections in the nose.

A few words regarding the treatment of the acute attack. First of all, let me again remind you to do little or nothing to the nose, during this stage. One of the best means of combating the inflammation of the sinuses is the use of Bier's hyperemia band, around the neck. It is placed tightly around the neck, immediately above the clavicle, the aim being to produce a leukocytosis in the region of the affected part. It is allowed to remain on for about three hours and is then taken off for an hour and replaced after that time. This is repeated for several days. The band is contra-indicated in acute suppuration of the middle ear, in peritonsillar abscesses and high blood pressure.

Another valuable therapeutic means is the use of the ultra-violet ray. We make use of physiotherapy in not only the treatment of acute inflammation but also as a prophylactic measure, recognizing the fact that the skin is the best immune organ of the body. In adults, rest in bed and the administration of aspirin and codeinae is indicated. If there is nasal obstruction, 0 5 per cent cocaine in two per cent boracic acid solution may be sprayed into the nose at frequent intervals. If this does not relieve the headache, the application of heat by means of one of the numerous lamps used for this purpose, or the placing of cotton tampons saturated with five per cent solution of cocaine in the middle meatus, may be of benefit. Do not use adrenalin because of the reaction which often takes place after its use. Ephedrine is probably less irritating and may be tried.

In sub-acute cases, infraction of the middle turbinate often relieves the patient of the headache, for it is a known fact that headache is not always the result of a disease of the sinuses but may be caused by pressure of the middle turbinate against the lateral wall of the nose. We must not forget that an acute nasal sinus infection is very often but an exacerbation of a chronic disease which may require surgical intervention after the acute symptoms have subsided.

Children with nasal sinus disease should be given food rich in vitamines, such as lettuce, tomatoes (raw or canned), fruit juices, cod liver oil, and plenty of milk. If the child is subject to frequent colds use ultra-violet radiation. Give them small doses of iodine and if they have nasal obstruction, 1:5000 adrenalin may be cautiously used. Better still, a salve containing one grain of cocaine to an ounce of vaseline placed into the nose at frequent intervals. Small doses of aspirin are also indicated in acute cases. In older children we use suction and irrigation treatment, especially in the subacute and chronic cases. When the antrum is chronically diseased, an intra-nasal operation on the antrum, with subsequent irrigations of the cavity, may be necessary.

In conclusion let it be said that the nasal accessory sinuses must be taken into consideration by the general practitioner, if all possible foci of infection are to be uncovered which may be the cause of the existing disease. This is especially true in patients with chronic toxemia, when other causative factors have been excluded, and in many individuals suffering from repeated attacks of bronchitis. If the importance of this subject has been impressed upon you, in merely a moderate degree, then the purpose of this address will have been fulfilled.

INFECTIONS TREATED WITH BACTERIOPHAGE AND ANTIVIRUS FILTRATES

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(Preliminary Report)

Several months ago we began experimenting with the bacteriophage. It was found to be a most striking laboratory phenomenon. Cultures of various organisms could be almost entirely lysed by infinitesmal amounts of the bacteriophage, and the lysis could be transmitted through any number of cultures becoming stronger as culture after culture was passed.

Might bacteriophage be used to kill the bacteria in a wound or infected organ as it can be used in a tube? We began by selecting certain hopeless cases in the hospital for experiment. It was inconceivable that harm might result from the treatment directly as it is only a sterile broth, and as all other available means of therapy had been tried without results it was deemed proper to try this as a last resort. Though we began without hope of improving these desperate conditions, the results were encouraging from the very first in spite of our very obvious inexperience. As case was added to case we became convinced that we were using a therapeutic agent of remarkable powers.

With further study of the cases and review of

the literature we have come to believe, however, that the curative effects probably are more to be attributed to the effect of the antivirus phenomenon developed by the French bacteriologist, Besredka, rather than the bacteriophage though the latter may be responsible in part. In each case treated to date there has been an active bacteriophage action in the culture *in vitro*, but inasmuch as the techniques for the production of bacteriophage filtrates and antivirus filtrates are alike in that a culture of bacteria is filtered, and the filtrate used, it is impossible at this moment to say which is the active agent.

Experiments are now in progress in which the phage is left out, and the cultures incubated a longer time before being filtered and used. Report on these will be made later. It is of interest to know that this latter method of treatment known as "local immunization by the method of Besredka" has been much studied in continental Europe, while practically nothing has been done in America or England. In a fairly complete bibliography thirty-six titles are in French, twelve are in German, and not a single one of original value is in English. Careful study of these articles reveals that they almost uniformly report the most amazing results, and yet one cannot fail to see that much of the work has been very carefully done.

Before giving the details of the treatment certain fundamental principles should be made clear:

1. There is a feeling on the part of many physicians that vaccine treatment except in a few conditions has not come up to the expectations of the earlier days of bacteriology. Such is the fact as we see it today. The theory of the use of vaccines as a means of producing immunity for prophylactic or therapeutic purposes remain impregnable, however. If vaccines have failed it is because we have not learned to use them properly. We may need to learn how to apply the antigen in the form of a vaccine to the tissue in the way that nature applies it, but once we learn to get the proper antigen, and then to apply it properly, there can be but one result, and that a favorable one. Nature has no other way of producing immunity than by contact of the antigen with the tissues. Certainly nature never uses a hypodermic injection in the arm for a carbuncle on the neck.

Specific immunity does not come from sunlight and fresh air, from quartz light or vitamines, from clean food or sanitary plumbing, or in any other way than by the reaction of the host to the stimulation of the germ or its metabolic products. If vaccines do not always work as we would wish we should then renew the search for vaccines that *will* work.

2. We have come to regard immunity in terms of serology. There are in the textbooks lengthy discussions of the many immune properties of serum, and all must admit that these are exceedingly important. Many therapeutic and prophylactic sera are on the market and are of inestimable value, but all of them confer only a *passive* immunity, and passive immunity is always transient, and subject to the dangers of anaphylaxis and serum sickness. *Active* immunity is much to be preferred if it can be attained.

We have been so under the influence of the humoral theory of immunity that we have forgotten that the living cells—both fixed and wandering—of the body have powerful protective devices of their own quite apart from the protecting serum in which they may or may not be bathed.

3. We need also to be reminded that most of our infections are local before they are general; that indeed the great majority of them never get out of the local stage; and that even when generalized most of them will speedily clear up when the primary focus is eliminated. Wound infections, erysipelas, gonorrhoea, furunculosis, acne, eye, ear, and sinus infections, abscesses, cystitis and a great number of other conditions are primarily strictly local infections producing only local manifestations, and combatted by local reactions. It is then apropos to attempt to treat them by the method of local immunization.

In the acute stage of gonorrhea there are no antibodies to be detected in the blood serum, but the cells of the urethra put up a strenuous fight against the invader as is well known. There is no need in this stage to immunize the entire body as is usually attempted, but only the urethra, and the approach of the antigen to the tissues should be from the surface as in the natural process.

4. We have regarded the skin and mucous membranes as convenient covering and lining. We have emphasized the important of a physically intact integument, but have failed to appreciate the enormous immunologic significance of the skin and mucous membrane as an organ. We have discussed the impermeability of the skin as if it were a rubber glove, but have failed to grasp its significance as a layer of living cells guarding the deeper cells of the body from external invaders. It is the skin that first comes into contact with germs, and so quite reasonably we might expect it to have resistive powers.

That the skin is capable of extraordinary powers of immunization has been proved by Besredka and his followers. Until recently it has been impossible by any known method to immunize the small laboratory animals against anthrax. Besredka has, however, been able to immunize them not only against one lethal dose of the germs, but against one thousand lethal doses, by the simple expedient of rubbing onto the shaved skin the filtrate from an old broth culture of the germs. This fact has been repeatedly confirmed by many separate investigators.

The same experimenter by local application of his staphylococcus antivirus has been able to

make one side of an animal immune to the injection of living staphylococcus, while the opposite side of the same animal was highly susceptible. Carrere has been able to immunize one eye of an animal leaving the other susceptible. Injection of the living homologous germs into the immunized eye causes but temporary inconvenience, while injection of the same amount of the germs into the other eye results in panophthalmitis and complete loss of the eye.

Our method of preparing the filtrate has been to isolate the causative organism, and grow it in broth. Various laboratory strains of bacteriophage which we have isolated from diverse sources then have been tried out in the culture. The most active strains of bacteriophage has been chosen. In case none of the strains will lyse the organism, a few transplants in contact with the bacterial growth will usually bring out a sufficient activity.

After twenty-four hours the lysed culture is filtered through a Seitz filter—equivalent of the Berkefeld candle—and is then ready for use.

We cannot here go into the theory of the nature of the bacteriophage as it is an enormous subject and very technical. A great number of papers have been written concerning its therapeutic use in a wide variety of conditions. Most of the French and German investigators report most excellent results, while the papers in English are about equally divided among the favorable and the unfavorable. It is significant that most of the unfavorable reports have been on small series of cases or without a preliminary demonstration of the activity of the bacteriophage strain used when in contact with the homologous organism.

Antivirus is prepared in much the same way except that the bacteriophage is left out and the cultures are incubated until no further growth takes place, before they are filtered. It is evident that the bacteriophage filtrate will always contain a certain amount of antivirus, and for this reason it is uncertain at the present stage of our studies which is responsible for the results we have obtained. We ask your indulgence in presenting our cases at this time, but feel that the importance of the subject warrants a preliminary report.

Early in the study we injected the filtrate subcutaneously, but have more recently come to the conclusion that this is wrong. It is best used as a wet dressing directly on the wound, or instilled into the infected cavity. Remarkable changes have been observed in the series of over twenty cases which we have treated. That these results bear a casual relation to the therapy admits of little doubt, as they have followed very promptly in cases that were static or going downward and have been mostly cases of very long standing.

Boils and other painful inflammations show almost immediate cessation of pain. So prompt is this relief that one who has not observed it may well be excused for being skeptical, but practically all French and German authorities comment upon the same point at length—and without being able to arrive at an adequate explanation. Boils are either quickly aborted, or are greatly hastened in their evolution. The pus from them is more liquid than common, and the core very promptly separates and comes out leaving a perfectly clean crater in record time. The development of other boils in the adjoining skin is practically always checked and well developed lesions show an amazing lack of soreness.

Infected wounds and bed sores very promptly become clean and odorless. Granulation tissue appears in a few days and healing begins. Temperature has precipitously dropped in a few hours after the first application, both in our experience and in that of the foreign investigators.

To date we have had most excellent results in five cases of furunculosis, six cases of acne (very bad cases of long standing), three bed sores, three cystitis, one mastoiditis, one subphrenic abscess, one osteomyelitis, and one septicopyemia. The following cases are of particular interest though every case treated has shown improvement immediately after the treatment began, and if time permitted might well be reviewed.

CASE REPORTS

1. Mr. C., age 69, had suffered for months with enlarged prostrate finding it necessary to use a catheter. Cystitis resulted, a suprapubic cystotomy was done but the condition persisted. Two large bed sores developed, one about the size of the two hands together, and the other, half so large. A periurethral abscess developed, and the patient was running a septic temperature. He was very much emaciated, and it seemed but a matter of a few days to the end.

Staphylococcus aureus and bacillus coli were isolated from the urine, an active bacteriophage against the two was found, and we were ready to begin treatment just as we were notified that the patient would live but a short time. The filtrate was instilled into the bladder, and the bed sores were washed with it. The next morning the temperature was practically normal and remained so with very slight variations. In two days the urine was much less turbid, though it never became clear, and the bed sores were clean and without odor. A week later one of the bed sores was beginning to heal. The other was delayed in healing until a flap of skin was cut off.

After six weeks the sores were healed and it was proposed to finish the operation by removing the prostrate. The patient chose, however, to go home and so was released. (Long hospital case).

2. K. B. (Indianapolis City hospital) colored boy, age 15, had a diagnosis of complete transverse myelitis. There was loss of control of bladder and bowel and complete sensory and motor paralysis of the lower extremities. On the legs, thighs and hips were numerous large bed sores

and several small ones. The sores were infected with staphylococcus, bacillus coli, and bacillus pyocyaneus, and were getting worse in spite of all treatment. Large amounts of pus, and very bad odor made the case a very hard one. It was considered to be absolutely hopeless and we were given it in the hope that we might make it easier to take care of.

Active bacteriophage was obtained. Immediately after its application the odor and pus stopped, the wound became dry and clean. Within a week granulation tissue began to appear, and there would be little spots of bleeding when the bandage was taken off. The upper portion of the two sores on the hips had some sensation left, and the patient complained of itching and burning sensations indicating healing. The large sores are now closing in and at least one of the smaller ones has completely closed. No other medication on sores was used.

3. Mr. B., medical student, age 20, had an extremely bad case of pustular acne, there being about thirty-five pustules with pus in them and others coming or receding when we began treatment. Staphylococcus albus was isolated. Active bacteriophage was obtained and incorporated in soft agar. After washing the face carefully the agar was rubbed in once a day. There was a change in two days. At the end of four days classmates who knew nothing of the treatment, remarked about it. At present, after six weeks, the face is smooth and clear without scars.

4. Mr. L., medical student, age 21, had very bad acne with much scarring and indurated masses under the skin of the face. Treatment as in Case 3 with very prompt results. Indeed there has not been a new pustule since the treatment began. Face became much softer, indurated masses were emptied of their pus, now much more fluid. Very remarkable improvement was noted in a few days. After a month the face shows scarring, but no active lesions.

Case 5. Mr. J., age 17, was sent in by Dr. Gastineau as the worst case of acne that he could find. His face presented a remarkable picture, being red, indurated and covered with nodules. It was sore and stiff. Treatment as in other cases described was begun. After the first week the face was much softer, less sore, and the pus was much more fluid. Whereas, in the beginning, little pus could be obtained, an amazing quantity was now expressed from the lesions on the face. A week later the face was still more improved but there was little pus to be found. At present, after five weeks, there are no new lesions, and nearly all of the old ones are gone leaving only a blotch which will clear up in a short time. He had lost his job because of his face, and was shunning every one. Now he has a job and is doing well.

6. Mr. W., medical student, was subject to boils which would last a long time. One came in his nose causing very severe distress. After treatment with alpine and infra-red light it grew worse for the next two days. He was in very great pain and was cautioned not to manipulate it in any way. A filtrate intended for another case of boils was applied in the form of a tampon in the nose, renewed every hour, and a wet dressing on the outside. This was at 10:30 a. m. After 2:00 p. m. of the same day he had not a twinge of pain. After twenty-four hours the nose was no longer sore except just over the boil. After forty hours the boil opened and drained several drops of very liquid pus. After forty-eight hours the nose was well.

7. Mr. A., patient at City Dispensary, age 31, had about a dozen boils on the left forearm. Was treated with material intended for another case and got immediate relief, going back to work in a few days. Three weeks later he was back with many more boils and a carbuncle on the back of his hand. Both forearms were covered with boils, *except in the area treated previously*. All of the lesions were very sore. Material prepared from his own pus obtained on the occasion of his first visit was applied. Relief from the pain was very prompt, and two days later we found the lesions much improved, and amazingly painless when pressed and manipulated. The hands which had been stiff before were now freely mobile. Several of the boils had opened leaving very clean craters. Pus from them was quite liquid. There were no new lesions after the second day in spite of the fact that there was sugar in the urine and other signs of diabetes mellitus.

8. F. B., age 15, patient in Riley hospital, was having subcutaneous abscesses appear at different places on his body at intervals of a few days. When opened these abscesses would drain for a long time before healing. One was aspirated and the bacteriophage filtrate was injected into it and another developing lesion. Both of these lesions came to pus formation but when opened the pus was found quite liquid and the openings were soon clean and healed promptly in spite of his run down condition. No new lesions appeared. The same material was applied to his face which showed a bad case of pustular acne without scarring. The acne is now completely gone though he has had no other treatment for it.

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CORONARY ARTERIAL DISEASE*

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Coronary arterial disease constitutes in present day medicine a redoubtable adversary whose destructive power is a mighty factor in making heart disease one of the greatest individual causes of death. It is the nemesis of kings and paupers, and makes no distinction of class or caste. Many famous men of medicine have died as the result of some coronary disorder, notably Morgagni, Panum, John Hunter, Charcot, Nothnagel, William Pepper and Neuhof. Owing to its frequency among medical men some one facetiously suggested the term "doctor's disease."

ANATOMY

Probably the most comprehensive monograph on the anatomy of the coronary circulation was published by Spalteholz in 1924. Experimental study of the vascular system of the heart has been concerned with the sources of the blood supply, the extent of anastomosis between vessels and the effects of closure of these vessels. Conheim's postulate that the coronary arteries were end arteries has been definitely disproved. The methods of investigation have included dissection of the heart of man and of animals, injection of the coronary tree by opaque mediums for roentgenologic study,[7] injection and corrosion methods, experimental closure of the coronary vessels in the heart of living animals, perfusion of the animal heart and measurements of coronary blood flow in the heart of living animals. Enlightening studies are those now being conducted by Whitten of the Mayo Clinic; he injects the chambers of the heart and the coronary veins with white celloidin and the right and left coronary arteries with colored mediums. After hardening, the tissue of the heart is entirely digested by strong acid, only the hardened celloidin caste of the heart and the vessels being left. This study, although only well started, has already thrown doubt on previous experimental work.

To state matters rather briefly, it can be said that most of the heart's circulation comes from the coronary arteries, some from the thebesian vessels and a small amount from the connections of the coronary arteries with vessels outside the heart.

The degree and extent of anastomosis of the coronary arteries in the normal heart vary greatly as shown by Oberhelman and LeCount, who also showed that the degree of anastomosis determines the response in health and disease. Gradual occlusion of coronary branches, as by atherosclerotic changes, results in the establishment of anastomotic channels; this is often the explanation of the protean clinical manifestations of the disease.

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CLINICAL FEATURES

Many cases of coronary arterial disease are not recognized as such, owing to the generally accepted use of misleading, though convenient, terms such as chronic myocarditis. This term in its correct sense indicates an inflammatory and therefore an infectious disease of the myocardium, which in reality is rare except in association with endocardial valvular disease. In order to justify the diagnosis of myocarditis the pathologic changes must be irrevocably linked with a causal infection, and they must conform to those resulting from the invasion of micro-organisms. These changes comprise interstitial lymphocytic or polymorphonuclear infiltration, abscess formation, Aschoff nodules and parenchymatous changes. In most of the cases in which the clinical diagnosis of chronic myocarditis has been made, necropsy fails to substantiate the diagnosis. Most of these cases are in reality disorders of the myocardium dependent on coronary sclerosis, hypertension or hyperthyroidism.

The data forming the text of this paper are based on 1000 unselected cases of coronary sclerosis and on necropsy observations when available.

Sex and age: The predominance of males in this series is striking. There were 814 males and 186 females, a ratio of 4.5:1. This predominance in males is probably due to the fact that men, as a group, are subjected to greater stress and strain during life's journey than are women. It is interesting to speculate what effect the life of the modern woman will have on the coronary vessels, since virtually all the occupations of men now have representatives of the female sex, and the use of tobacco among them is becoming more universal. The coronary vessels are subjected to inestimable stresses during the span of life and it is little wonder that they so often fail to sustain the normal expectation of life.

Coronary sclerosis is notoriously a disease of middle and later life. Eighty per cent of the cases in this series occurred in the sixth and seventh decades. I have, however, records of three cases in the third decade in which marked coronary sclerosis existed, as shown by necropsy. In one case, that of a girl, aged twenty-three, death occurred from coronary thrombosis with myocardial infarction.

TYPES OF THE DISEASE

Type characterized by paroxysmal cardiac pain: It is not uncommon for the terms coronary

sclerosis and angina pectoris to be used synonymously; yet clinically and pathologically they have been shown to be often quite distinct.

I discuss angina pectoris with trepidation owing to the wide-spread controversy that has extended from Europe to this country. The confusion that has arisen regarding angina pectoris may make it advisable to abolish the term and introduce the descriptive term, cardiac pain associated with coronary sclerosis. Before discussing this form of the disease further I must define my interpretation of the term angina pectoris since it is used in different senses. Some physicians use it to designate a definite disease with a train of clinical symptoms and characteristic pathologic lesions, while others use it to designate a syndrome common to many diseases.

Huchard attributed the first observations on coronary disease to Drelincourt in 1700. Full credit for the first accurate description of these painful seizures must be accorded Heberden (1768). So vivid and realistic was his description that I shall quote briefly from his original thesis: "There is a disorder of the breast marked with strong and peculiar symptoms, considerable for the kind of danger belonging to it, and not extremely rare, which deserves to be mentioned here at length. The seat of it, and sense of strangling and anxiety with which it is attended, may make it not improperly be called angina pectoris.

"They who are afflicted with it are seized while they are walking (more especially if it be up hill, and soon after eating) with a painful and most disagreeable sensation in the breast, which seems as if it would extinguish life, if it were to increase or to continue; but the moment they stand still, all this uneasiness vanishes. In all other respects the patients are, at the beginning of this disorder, perfectly well, and in particular have no shortness of breath, from which it is totally different. The pain is sometimes situated in the upper part, sometimes in the middle, sometimes at the bottom of the os sterni, and often more inclined to the left than the right side."

Other observers gradually deviated from Heberden's classical description and the term false or pseudo angina pectoris was, regretably, introduced into medical literature: the term has no meaning whatsoever. Subsequently, such further elaboration as hysterical, toxic and vasomotor angina, were introduced; there was such a confusion of types that the true issue was almost hopelessly submerged. Some degree of order has been restored during the last decade, chiefly by the teachings of Mackenzie and Allbutt. They were not in accord as to the anatomic lesions responsible for these painful seizures, yet both attempted to revive the original definition of Heberden and to restrict the use of the term angina pectoris to the disease which he so clearly described.

It was Jenner who first associated angina pectoris with disease of the coronary arteries, while Huchard believed that disease of the coronaries or the aorta, especially if the coronary orifices were encroached on, was the anatomic cause. More recently Allbutt formulated his concept that angina pectoris is due to disease of the thoracic aorta, particularly of the root of the aorta, and with involvement especially of its outer coat. He insisted that the coronary arteries and the myocardium played no part in the production of pain in angina pectoris. Mackenzie, diametrically opposed to this view, held that in angina the symptoms were produced by exhaustion of the myocardium, and that coronary myocardial disease were essential.

Analyzing these opinions carefully and adding to them a personal experience based on adequate correlation of clinical and pathologic data, I find it impossible to relinquish the hypothesis that coronary disease is fundamental in the production of angina pectoris. This view gains material support by a consideration of the characteristic syndrome that follows the sudden occlusion of a coronary artery by a thrombus or embolus. Mackenzie's theory of the production of cardiac pain is very comprehensive and is in fact the only theory submitted thus far that explains cardiac pain under all known pathologic conditions.

The pain at times attending other forms of heart disease differs from that of angina pectoris, a detailed discussion of which cannot be undertaken here.

In this series of cases paroxysms of cardiac pain occurred in 421 cases (forty per cent). In most instances the character, origin and radiation of the pain agreed with the classical syndrome described by Heberden. In some cases, however, the radiation was bizarre, at times suggesting disease in other regions. A few years ago I reported a group of cases of coronary sclerosis which, in the origin and distribution of pain, simulated practically every known surgical condition of the abdomen.[22] The most frequent bizarre type was the sudden severe attack, usually in the middle of the epigastrium or right upper quandrant of the abdomen, radiating through to the back, usually precipitated by the ingestion of a heavy meal and associated with belching.[23] The symptoms have been recited as one so frequently hears them from the patient, and the first reaction to such a recitation is to believe that the gall bladder is diseased.

The importance of careful questioning and cross-questioning of the patients in middle life should be strongly emphasized. In each case the possibility of coronary disease must be considered. One should not rely wholly on the patient's voluntary statement of symptoms, as important details are often omitted and emphasis placed where it tends to mislead the questioner, such as

in the case of the patient who emphasizes the eating of a heavy meal, and does not mention the effect of physical exertion. I clearly recall the case of a man who came to the Mayo clinic presumably suffering from trifacial neuralgia. The pain was severe and always came on when he shaved. He neglected to state that undue effort also brought on an attack. He died suddenly during one of these seizures and necropsy revealed marked obliterative coronary disease.

The importance of correct diagnosis is apparent, especially when the condition may simulate a surgical disease.

Type characterized by myocardial failure: The syndrome of progressive myocardial failure occurs in about fifty per cent of the cases of coronary sclerosis. In the milder forms the syndrome is manifested by undue dyspnea on exertion, and in the more severe forms by the manifestations of congestive heart failure. These cases are still quite generally diagnosed chronic myocarditis, which is obviously fallacious since the pathologic process is not inflammatory but the result of chronic and usually progressive impairment of circulation of the myocardium. As a group, these cases show less marked sclerosis of the coronary vessels with much less tendency to obliteration of the lumen than do cases characterized by painful seizures.

The syndrome of myocardial failure was present in 496 cases (fifty per cent). The course of the disease was variable. If the disease is recognized early, before considerable injury has occurred, and if a proper cardiac regimen has been instituted and strictly adhered to, the chance of realizing a normal life expectancy is fairly good. The more advanced cases invariably progress. This group of cases shows the greatest incidence of auricular fibrillation occurring in coronary disease. In a recent necropsy study[26] of 117 cases in which auricular fibrillation had been present, coronary disease of this type was found in about sixteen per cent. Auricular fibrillation is rare in the cases characterized by painful seizures.

Death from progressive heart failure occurs in about sixty-four per cent of the cases, while sudden death occurs in about thirty-six per cent. Occasionally painful seizures occur but these are more infrequent than the attacks of paroxysmal dyspnea.

Type characterized by paroxysmal dyspnea: In about ten per cent of cases of coronary sclerosis the dominant symptom is paroxysmal dyspnea, frequently nocturnal, that is, precipitated when the patient is at complete rest. These cases are often referred to as cardiac asthma. Pulmonary edema is frequently but not always an associated phenomenon. Paroxysmal dyspena is not characteristic of coronary sclerosis but also accompanies other forms of cardiac disease.

There were eighty-three such cases (ten per cent) in this series. Death occurred early and mortality was high, the paroxysms of dyspnea occurring with advanced cardiac disease. I have observed several cases in which painful seizures were supplanted by paroxysms of dyspnea shortly before death.

Occult type: Another form of coronary sclerosis warrants mention, namely that in which there is little or no diagnostic evidence of its presence during life. For want of a more comprehensive term, it is referred to as the occult type.[27] It is usually identified by the pathologist. Osler called attention to the fact that in a certain number of these cases the heart sounds are clear-cut, the pulse is good, and there are no obvious signs of cardiac disease in spite of extensive disease of the coronary arteries. In my experience these cases occurred chiefly in the later periods of life and were complicated by outstanding diseases of other parts of the body, such as nephritis, diabetes mellitus and carcinoma. In all the cases studied at necropsy death was due to causes unrelated to the heart.

CORONARY THROMBOSIS

Sudden occlusion of a coronary artery by thrombosis or embolism is not an infrequent catastrophe. Many of these cases are still being mistaken for ptomaine poisoning and acute indigestion.

A sharp distinction must be drawn between the gradual narrowing due to atherosclerosis and the sudden occlusion caused by thrombosis and embolism. In the first case, the heart is given an opportunity to develop anastomotic circulation in some instances, while, in the second, this chance of adaptation is precluded if a larger artery or one supplying a vital area becomes obstructed.

Huchard accords the first observation of coronary thrombosis to Cruveilhier in 1850. It was Weigert who, in 1880, actually proved the existence of cardiac infarction.

There is little doubt but that acute coronary obstruction is the most frequent cause of sudden death. It has been generally conceded that the causes of sudden death, with the exception of death due to poison, are to be found only in the heart, the lungs and the brain. It is evident from increasing numbers of necropsy reports from many centers that the heart undoubtedly ranks first. It is probable that acute coronary obstruction is on the increase in this country although it must also be said that diagnosis is likewise becoming increasingly accurate.

There is frequently a history of preceding painful cardiac seizures, undue dyspnea on effort, or attacks of paroxysmal dypsnea. At times, however, the acute occlusion gives the first intimation of cardiac disease. Benson asserts that thrombosis in the cases without previous sclerotic narrowing of the arteries is usually fatal, and that this probably accounts for most of the cases of sudden death in the first attack. The more protracted cases manifesting anatomic infarction,

even repeated infarction and formation of ventricular aneurysm, are usually those of combined thrombosis and preceding atherosclerosis.

The most striking symptom is the persistence of pain, usually for from two to eight hours; in one case that came under my observation, the pain lasted uninterruptedly for ninety hours. Prolongation of a painful cardiac seizure should always direct attention to the probability of acute coronary obstruction. The origin and the distribution of pain are not always typical. The pain may be retrosternal and radiate into the left arm or both arms. It may be in the epigastrium without radiation, or it may arise in other regions. Death may be instantaneous, life may be prolonged for a few hours or days, or recovery may occur with a varying residuum of cardiac incapacity.

During the attack the face is usually of a leaden, almost ashen pallor. The skin is often cold and clammy; the features are drawn with suffering and there is an anxious look. Dyspnea commonly accompanies the pain, is often constant and at times paroxysmal. Respirations are shallow and rapid, the pulse thready and the blood pressure low. Fever, often attaining 100 to 102 degrees may be present within twenty-four hours of the onset.

General examination, soon after the onset of the accident, may reveal only weak, rapid heart tones. Often within eighteen or twenty-four hours a distinct pericardial rub is audible (usually to-and-fro in character) due to the inflammatory reaction of the visceral pericardium overlying the infarcted area. This observation has at times erroneously led to the diagnosis of acute pericarditis. If the infarct is large, the area of cardiac dullness will increase, owing to weakening of the myocardium. The upper part of the abdomen may be distinctly resistant and almost rigid on palpation, falsely pointing to disease of this region.

The leukocytes vary from 9,000 to 25,000 and in more than half the cases vary from 15,000 to 20,000. Careful study of the patient and of the number of leukocytes each day places in the hands of all physicians the simplest and most important prognostic guide. The polymorphonuclear cells usually comprise from eighty to ninety per cent of the leukocytes. Leukocytosis, within two hours after the onset of the attack, may be as high as 20,000. Libman has shown that, when the leukocytosis does not definitely recede within a few days, or if it increases with or without a preliminary decrease and there is no complication to explain it, progressive necrosis or intraventricular thrombosis, or both, are present.

The immediate complications of acute coronary obstruction are important and should be fully understood. In many cases a mural thrombus is formed in the ventricle underlying the area of infarction and may give rise to embolic detachments which often cause death. This seems to be particularly true when the infarct is situated near the apex of the left ventricle. Cerebral embolism is the most frequent complication, while obstruction of the mesenteric arteries and of the peripheral arteries, particularly of the leg, occur with considerable frequency.

If necrosis of the infarct progresses the heart may rupture spontaneously and death occurs immediately. When considerable myocardial weakening occurs in the vicinity of the infarcted area, the so-called ventricular aneurysm develops, usually leading on to progressive heart failure and, at times, to rupture.

Occlusion of the left coronary artery by thrombosis or embolism occurs with greatest frequency and most frequently in the anterior descending branch. Only rarely are both right and left coronary arteries blocked simultaneously.

The clinical syndome attending acute closure of the right coronary may vary materially from the classical syndrome already described. I have observed an interesting group of cases (the diagnosis being subsequently established at necropsy) in which pain was absent but severe paroxysms of dyspnea occurred. A few days after the infarction the liver became distended and often pulsated, owing to the failure of the right side of the heart. In other respects these cases presented the features characteristic of coronary thrombosis.

It is not unusual at necropsy to find an old myocardial infarct that has completely healed. This does not indicate complete recovery from a profound cardiac insult since eventual death from heart failure is common.

Occasionally events occur within several hours or days that permit the clinician to localize the area of infarction accurately. I have observed two cases of acute coronary obstruction with myocardial infarction in which complete heart block developed relatively soon with the attendant epileptiform convulsions of the Stokes-Adams type.[24] These phenomena definitely established the interventricular septum as the site of the infarction; it had thus interrupted the transmission of impulses through the His bundle.

PATHOLOGY

In a brief statement of the pathologic changes of coronary disease it may be said that the vascular lesion is essentially intimal atherosclerosis.[2] It is extremely doubtful whether syphilis is ever a factor in the production of coronary sclerosis. Extensive syphilitic aortitis may so constrict the coronary orifices as to be the cause of death, but, even here, the syphilitic process seems to end abruptly at the points of origin of the coronary vessels. The changes resulting from myocardial infarction are too well known to require description here. The myocardial lesions of coronary

sclerosis consist chiefly of fibrous changes, occurring either in patches or diffusely.

PROGNOSIS

The prognosis in cases of coronary sclerosis is grave and extremely uncertain. The outlook, in general, depends on the integrity of the myocardium and the condition of the general arterial system. It depends, to a considerable degree, on the co-operation of the patient, who must prepare himself to live on a level commensurate with the injured heart.

Acute coronary obstruction carries with it the highest mortality: at least half the patients die in the initial attack. Considerably more die within the year following the coronary accident.

Coronary sclerosis with painful seizures and with paroxysms of dyspnea is also attended by a high death rate.

A general idea of the cardiac mortality in those cases manifesting painful seizures is shown by the fact that in forty-seven per cent of a series death occurred during a period of five years. In another group in which the data were based chiefly on necropsy records, it was found that death occurred suddenly in eighty-three per cent. Death may occur suddenly in the first attack, without antecedent symptoms, the majority of these cases being instances of coronary thrombosis or embolism. Death may result from progressive myocardial failure after several months or years of painful seizures; not infrequently the terminal picture is that of congestive heart failure. The painful attacks may cease, only to be supplanted by paroxysms of dyspnea, death finally resulting from myocardial failure. Occasionally the painful seizures cease spontaneously and death occurs from some disease unrelated to the cardiovascular system.

Sudden death and gradual failure occur with equal frequency in the type of coronary sclerosis characterized by progressive myocardial failure. In these cases as a group the mortality rate is slightly lower than in those attended by painful seizures.

ELECTROCARDIOGRAPHY

The electrocardiograph is a valuable adjunct in the diagnosis of coronary sclerosis, revealing significant abnormalities in about seventy per cent of the cases. These changes consist chiefly in negativity or inversion of the T-wave in isolated or combined leads. Complete and incomplete bundle-branch block are likewise frequent graphic abnormalities displayed in coronary disease. Many cases of complete heart block have their origin in obliterative disease of those coronary branches supplying the His bundle.

T-wave negativity is not limited to coronary arterial disease but occurs also in other cardiac lesions. In a recent necropsy investigation of 130 cases in which significant T-wave negativity had been present, I showed that either well-advanced coronary sclerosis or cardiac hypertrophy of 500 gm. or more occurred in eighty-two per cent of the cases.[25] In many cases coronary sclerosis and hypertension co-exist, the latter being chiefly responsible for the attendant cardiac hypertrophy.

Cases of coronary thrombosis often reveal most unusual graphic records showing innumerable transitions if noted day by day. If death occurs within the first few hours or the first day the electrocardiogram usually remains unaltered. I have observed one exception to this, a case in which the graphic record was normal an hour before the coronary occlusion occurred and showed marked deviations a half hour after the attack. Changes in the T-wave are the usual abnormalities encountered.

TREATMENT

I enter into a discussion of the treatment of coronary sclerosis with reluctance, largely because few valuable methods have been introduced during the last few years. The justification for doing so, however, is to reopen the subject of sympathetic neurectomy in those cases characterized by painful seizures. Since Jonnesco's report of a case of sympathetic neurectomy, a wave of unwarranted enthusiasm has swept over this country, and unquestionably many such operations have been performed when the indications were doubtful. Jonnesco removed the nerves of the left cervical sympathetic chain and the upper thoracic ganglion. Other operators severed the left sympathetic trunk below the superior cervical ganglion as well as the superior cardiac branch. Still others added to this procedure resection of the superior cervical ganglion. Some report results from resection of the depressor nerve alone. It is interesting to note the variations in operative methods that have been advised and enlightening to observe the great discrepancy in results obtained from similar and dissimilar procedures. It becomes apparent that exact anatomic and physiologic knowledge regarding the sympathetic nerves is still lacking and it is extremely questionable whether such operative procedures should receive encouragement at this time. The most enthusiastic exponents are found among the surgeons who perhaps have momentarily wandered beyond their province.

These procedures, even if they were uniformly successful in abolishing the painful attacks, in no way modify the course of the underlying disease but are only radical symptomatic methods which expose the patient to a far greater hazard than before, by removing his only warning sign. It is of interest in this connection that the incidence of coronary thrombosis is not reduced after sympathetic neurectomy and, when this accident occurs, it is accompanied by the same degree of pain that characterizes acute coronary closure.[13]

A simple and relatively safe method in selected cases is the paravertebral injecton of the lower cervical and upper dorsal nerve roots on the left

side with procaine; if relief is obtained, the injection is repeated with absolute alcohol. I advocate this procedure only for severe attacks of pain at rest, which have been uninfluenced by the usual medical measures.

Probably the most satisfactory drug in the treatment of these cases is theobromin and allied substances. Definite relief is obtained in about one-third of the cases. This group of drugs increases coronary blood flow and myocardial nutrition by its dilating effect on the terminal coronaries. This has been shown by the experimental studies of Smith, Miller and Graber; they used caffeine sodium benzoate, theobromin sodio-salicylate, theophyllin and euphyllin. In some of their experiments, coronary blood flow was increased from forty to ninety per cent.

Theobromin and theocin have gained greatest favor in clinical practice; the former is readily tolerated and its administration can be continued indefinitely.

The introduction of a definite cardiac regimen is, of course, always indicated, and the restrictions imposed must be determined by the status of the individual case.

Digitalis is contraindicated except in the presence of congestive heart failure and even then must be given with greater caution than is necessary in other cardiopathies. The nitrites are, of course, valuable in controlling the immediate attack but their use is rather limited.

The paroxysms of dyspnea, at times the predominant manifestations of coronary sclerosis, offer a real therapeutic problem. The nitrites act successfully at times and, when pulmonary edema is present, atropine may be profitably combined with them.

Many major problems still confront the profession regarding the nature, prevention and treatment of diseases of the coronary arteries.

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MEDICAL SOUTH AMERICA

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After a sojourn in South America I was impressed with the medical activities of our Latin American cousins. South America can boast of as good a medical curriculm as any in the world —yet its interpretation of the art is a medical hybrid, being a mixture of European-North American and native characteristics.

I was told at the San Macas University located at Lima, Peru, that the requirements for a medical degree consisted of high school, college, then seven years medical work. In case of an exceptionally bright student, two years may possibly be cancelled—but rarely is such the case. Graduates are required to be conversant with one other language beside their own—usually this is German or French. As a result the students come from the aristocracy or the well-to-do, thus closing the door to the poorer classes. Consequently medicine in South America is the stepping stone to society more than to science of medicine. Following this deduction a little farther, we conclude surgery dominates these Latin Americans, not because by nature they are more mechanical and skillful, but the better fees defray the expenses of their social obligations, which would not be forthcoming if the more scientific but less remunerative field of internal medicine be pursued.

The medical profession of South America is set on a pedestal, more so than any country I have ever visited; but such is the characteristics of the temperamental Latin Americans. We also see it in their religion, the priest being their alpha and omega. However, today in the political, religious and medical economics of this country the light of liberty is illuminating the horizon of doubt and ignorance, reflecting the spirit of Europe and U. S. A. in the larger cities. Lima, Arequipa, LePaz, Santiago, Buenos Aires, Montevideo, Rio, Sao Paulo, and such, have hospitals and medical institutions modern to the nth degree; yet strange to say these same institutions seem to be blind to the essentials of scientific sanitation. Few are thoroughly screened, fewer have

availed themselves of the health-giving properties of air, light and sunshine, even though Buenos Aires means pure air, and Valparaiso, the city of sunshine. On the west coast are several hospitals controlled by Americans or British. These, as a rule, employ more nurses—are more modern in equipment—and better screened. Especially is this true in the copper districts of North Chile. Unfortunately the laws in South America, especially in Chile, are such that it is difficult for a foreigner to practice medicine or surgery. The doctor must speak two languages, one of which must be Spanish, as all examinations are held in this language. In the remote districts and in the mountains the hospitals are small and lacking in the essentials of air, light, sanitation and dietetics. I marveled at the quantity and quality of meats served in this equatorial country. Also the impunity with which they ate the germ-laden vegetables and fruit, taking the gambling chance so prevalent in Latin American races. In Santiago is the largest but not the oldest medical school on the west coast. This school and hospital is conspicuous because of its few women nurses. This is true of entire South America. Most of the hospitals are dominated by the Catholic fraternity, employing as few nurses as possible.

When we consider the Latin American attitude toward women, we do not wonder at the small percentage of women in the nursing fraternity. They cannot adjust themselves to the freedom and liberties of our United States women. Seeing them in politics, in business, in medicine, is contrary to the courtly Castilian customs. Yet on the streets of Buenos Aires, Santiago and Rio, I saw feminine etiquette that was shocking even to a blasé North American. This inconsistency permeates through the entire Latin American blood. Raised on a pedestal, as is the profession, they will condescend to allow the daily papers to print glaring announcements of the leaders of the profession, advertising them in expertness from ingrowing toe-nails to revolting malignancy of the internal organs. Yet "Consistency thou art a rare jewel" will also apply to our own race. This I can say in all sincerity: the Latin American physician is courteous and hospitable to a fault—many are real students of the profession—many are excellent surgeons, comparing with our best American and European men. In research work also, some stand out prominently. Dr. Arcy has done much good work in the study of verruga. It was near Lima, enroute to Reo Blanco that I stopped in the district in which verruga is so prevalent. This dreaded disease called "bleeding warts" is confined to a district of some thirty square miles on the high plateau of the Andes. In building this road Henry Meggs, an American engineer, had verruga to contend with; employees by the hundreds would become infected, becoming useless or die from the disease. Little more is known of the disease today than then, no specific having yet been found.

In Quito Ecudore, the Rockfeller research is doing good work in the tropical diseases. Also in Sao Paulo, the jungles of the Amazon is being redeemed through medical research. Here also is located the famous snake farm—one of the most interesting features, not only in South America, but in the entire world. This farm consists of many enclosures, each containing a half dozen or more concrete beehive mounds. Around each enclosure is a mote which safeguards the reptiles. This farm is controlled by the Brazilian government, and all poisonous snakes are sent to this farm, the venom from which is used for antitoxin. Also the farm breeds a large, non-poisonous snake called the androcanda which destroys the poisonous varieties. This snake is distributed over the entire Brazilian republic. These two conditions have greatly reduced the mortality of snake bites in South America. The fact that people are being taught the importance of proper foot wear has reduced the mortality of snake bites from eighty to ten per cent. A much higher score than the other two. It is said, however, that a bite from the "jarracca" is certain death, the antitoxin having little if any effect.

Brazil can boast of more efficient public health congresses than any of the other republics, Argentine and Uraguay following second. Rio, Sao Paulo, Bahia, Buenos Aires, Montevideo can be called as progressive, even aggressive, in many medical and surgical attainments. Here we see in many of the higher institutions of medicine, facilities for the special study of individual diseases such as tuberculosis, goiter, hydatid infection and cancer. Special investigations are being made also in malariology. For the past five years Brazil has had one of the best colonies in the world for insane female patients. Because of its topography, climatology and geography, South America has tropical diseases with which we seldom come in contact. Trachoma, elephantiasis, and amebic dysentery are interesting to us because of their rarity. Judging from the work being done, I predict that within the next decade or two all these preventable diseases will be eradicated.

The South American history of yellow and malarial fever reads like romance. In remote antiquity natives learned that living on high land, in huts free from night air, immuned them from this dreaded sickness. In remote districts of Columbia, Brazil, Equador, Peru and Bolivia, the natives today fear the night air as much as the bite of a snake. It is interesting to wander among the market places in these districts and see how conspicuously herbs and plants are displayed for the purpose of counteracting the injurious effect of night air. As a consequence tuberculosis and bronchial trouble run amuck in this region. To

the splendid work done by Reed, Agramout, Carroll and Lazear—the latter losing his life in determining the carrier of yellow and malarial fever, is credited the high score to preventive medicine. To General Gorgas is due the credit of actually putting this knowledge in practice in the building of the canal. This feat only could have been done through the aid of medical science. So it is clear that our Latin American cousins are marching the road of science in the larger cities.

The hospitals in Lima, and on the western coast especially, are of Spanish design, built for the tropics—one story, high ceiling, and with large patios. The newer hospitals throughout the South American continent are installing modern North American ideas, some with American nurses. These newer hospitals have screens, which is not usual in South America. The physicians as a group, however, are not as expert in x-ray and laboratory work as in Europe or the United States. Especially is this true in Columbia, Peru and Equador. The hospitals in Chile are supported chiefly by the state under the management of the Sisters. The training schools draw from the poorly educated classes serving more as drudges than nurses. The American Mining Corporation has their own hospital conforming more to our standard. In Valparaiso the newer hospitals are also built on these plans. Operations performed by the hospital surgeon are gratis, the surgeon being paid a set salary. Personally I think this a splendid custom, as it places surgery economically where it belongs, removing the temptation of overcharge. As a result two conditions are improved —conservation and thoroughness. The one medical school in Chile is located in Santiago. The requirements for a degree are more exacting than in our country. One interesting feature of the Chile medical laws is that all post mortem examinations are conducted under the medical jurisprudence department of the medical school. This system is quite superior to our coroner method as practiced in the United States.

The chief medical school in Argentine is located in Buenos Aires, with a high rigid course. Only about one-fourth of the students graduate at one time. Many spend eight or nine years attaining their degrees. The general standard of education here is high—the republic having about 400 school buildings on the American plan. The pre-medical work is given in La Plato University —in connection with which is the museum, said to be the finest in South America. I spent the afternoon enjoying the anthropological collection which is especially valuable, containing as it does the dinosaur of South America, found near the Rio de Janeiro basin. Also the trephined skulls so numerous around the ruin of Macha Pacchi are found here in abundance. No one thing interested me so much as the shrunken heads, the technic of which is still carried out among the wild tribes of lower Equador and the Amazon. Buenos Aires has some thirty or more hospitals, most of them old. Trained nurses, as we know them, do not exist in South America, with but few exceptions. Being familiar with the loose traffic regulations of this city, one's first thought is that thirty hospitals wouldn't be sufficient to take care of the maimed and injured. Surprising as it may seem, their disregard of the speed limit does not show any great mortality list.

In Rio is a training school for nurses under the auspices of the Republic foundation, with an American superintendent; the enrollment is chiefly Portugese and Indians. The demand for trained nurses is limited, as natives depend on their maids or relatives for attention. Many hospitals are arranged with beds for the accommodation of the maid and relatives who are expected to do the nursing. This is an easy matter, as sufficient medicine is placed at the bedside to last twenty-four hours. Sedatives or enemaes are seldom used. Furthermore, the South American surgeon or physician does not require, neither does he demand, the assistance required by European and North American men.

Hospitals in Rio, Montevideo and Buenos Aires are either private, semi-private or public, the private being more pretentious but not more comfortable than the others. Many of the public institutions in South America are supported from lottery and racing clubs. In Buenos Aires ten per cent of all money wagered on races is given to the charitable institutions. One visiting the jockey club would be convinced that such a per cent would be no small item. This is taken care of by the Sisterhood. Rio also can boast of a splendid institution for tropical medicine. Most of the laboratory work of the state is done here. Ancon hospital is by all odds the most modern and best equipped of any in South America. Here also we find a scarcity of nurses.

After all it is primitive South America that contains most of interest to the well informed medical man. Cities are similar the world over, with their sociological forms and customs, but remote districts have an air of individuality, shocking or pleasing as the case may be, that elicits your interest. For example, in the mountains of Peru still exists the death doctor, with the peculiar privilege of despatching an undesirable person by simply dislocating the cervical vertebrae. The operation is said to be painless, and this art is handed down from mother to daughter. In the high lands of Bolivia, among the markets, can be bought herbs, roots and plants cultivated by the early Incas, for the cure of any and all diseases. Especially conspicuous are the herbs for the use of protecting one from the evil effects of fresh air and drafts. In many streams of the Amazon basin are fish reputed to have healing

properties. Especially the grinning fish, dreaded for its ferocity, but coveted for its transmitted power. On the high plateau of the western coast of South America are the half-starved, emaciated Quito Indians, especially found in the district of Le Paz, where they seem to own their existence to the coco leaves, from which cocaine is extracted. Before they exert themselves to the slightest task they place a cud of leaves between the gum and cheek, adding a little lye to facilitate the extraction of the cocaine, and within a few minutes you marvel at the endurance shown. As a result they are short lived, miserable, prone to tuberculosis and bronchial trouble. A very similar drug is the tobacco tree plant found in the valley of Columbia. The "Yerba Mata," a plant from which tea is made, found in Paraguay, Uraguay and Brazil, is reputed as possessing real medicinal properties. It is extensively used by the poorer classes in the Republics. It is said to be especially beneficial in counteracting the ill effects of a meat diet. It also is reputed to have antiseptic properties, being used by the superstitious for bronchial trouble. In studying some of the shrunken heads found in the La Platta Museum, I learned that this tribe, inhabiting the low lands of Equador and Brazil, use a poison called Mali obtained from a tree found there. This poison interested me for the reason that it acts on the respiratory system by suspending the lung action without poisoning the flesh of the victim. The natives kill their game in this manner for food. Frequently such animals as monkeys, are captured alive by shooting them with the poisoned arrow, afterward inducing artificial respiration until the poison is eliminated. In the museum at San Marcas, Lima, I had ample opportunity to study the trephined skulls that are so abundant in the ruins of Macha Pacca. These skulls are pre-Incas in antiquity, yet some archeologists claim that the holes in them are the result of trephining. My observation would lead me to the conclusion that many were diseased skulls, others had the appearance of being crushed or caved in from the violence of the clubs used by the aboriginees or the Incas who were not adverse to such warfare. Be that as it may, if they were trephined skulls, modern surgery has yet more to learn in bone surgery.

In conclusion I wish to say, that we have much to learn from the Latin Americans. It would be a mutual advantage to exchange lectureships and professorships in the teaching schools of the medical fraternity. We could teach them much in scientific internal medicine; they in turn might hold us somewhat in check in our aggressive surgery.

SPECIAL ARTICLES

NEWS NOTES FROM INDIANA UNIVERSITY

The annual founder's day banquet and initiation of new members was held by Mu chapter of Phi Chi medical fraternity Saturday, February 25, in the Travertine room, the Hotel Lincoln. Dr. A. F. Weyerbacher was toastmaster and speakers included Dr. Max Bahr, Dr. William A. Doeppers, Dr. Arthur M. Mendenhall, Dr. Carl Habich, Dr. Murray N. Hadley, Dr. C. O. Richey, Dr. Homer G. Hamer, Dr. Alfred Henry, Dr. Larue D. Carter and Dr. W. J. Wright. The initiates were Dr. M. V. Clayton, of Muncie, and the following students in the Indiana University School of Medicine: Paul Dietzke and Ralph Webster of Greencastle; Donald Wissinger, George Hazel and William E. Barnett, of Logansport; Gerald Young, of Huntington; Edwin Boldrey, of Bloomington; Marvin Habegger, of Berne; Harold Hilty, of Indiana Harbor; Paul Hattendorf and Ralph Shaner, of Fort Wayne; Carl Southard, of Noblesville; William Robertson, of Salem; Arthur Richter, of Flora; Carl Parker, of Kokomo; George Herrold, of Lafayette; Nicholas Keserick, of Gary; Walter Wilson, of Los Angeles, Cal., and Kenneth Meyer, of Bridgeport, Conn. New officers of the chapter who officiated for the first time were James E. Jobes, of Indianapolis, president; Emil Kenyon, of Carmel, secretary, and E. V. Norris, of Indianapolis, treasurer.

During the first four months of operation of the William H. Coleman hospital for women, new unit of the Indiana University School of Medicine, formally dedicated October 20, with a bed capacity of sixty-five divided between obstetrics and gynecology, one hundred and eighty babies were born in the hospital. There were 628 admissions and 205 different patients were enrolled in the out-patient department, which is chiefly devoted to pre-natal care and follow-up of post-operative cases. The resident staff consists of the chief resident physician, Dr. James D. George; two internes who are assigned to the hospital for certain periods as a part of their rotating service in the Indiana University hospitals, and three externes. The nursing staff is organized and directed by the Training School for Nurses, and the one hundred and seventy nurses in training at the present time, with their supervisors, are receiving abundant training and experience in obstetrical nursing. Many interesting obstetrical and gynecological problems have been referred to this hospital and some valuable data is being accumulated by the department of obstetrics of the School of Medicine, especially in the field of the toxemias of pregnancy and their management. In assuming responsibility for the welfare of patients in

private rooms under care of their own physicians, the School of Medicine reserves the right through the chief resident physician to keep itself informed of the progress and management of each case and to make recommendations or modify procedures to accord with approved methods. Physicians not members of the faculty of the School of Medicine whose professional attainments and ethical standards are acceptable to the medical council and who are in harmony with the procedures of a teaching hospital, may be approved for the conduct of private obstetrical cases in the hospital. As a teaching hospital the institution extends a cordial welcome to physicians generally who would like to visit the pre-natal clinics, make ward rounds or witness deliveries or operations.

The following births in physician's families are reported from the records of the Coleman hospital: Dr. and Mrs. Thurman B. Rice, February 3, a son, James Abel. Dr. Rice is associate professor of bacteriology and public health in the School of Medicine. Dr. and Mrs. Russell R. Hippensteel, February 1, a son, Donald Maurice. Dr. Hippensteel is assistant in pediatrics in the School of Medicine. Dr. and Mrs. Alfred A. Story, December 11, a son, Alfred Zeigler. Dr. and Mrs. E. H. Hare, January 18, a daughter. Dr. and Mrs. Cecil F. Clark, December 14, a son, Arin George Alexander. Mr. and Mrs. Lester B. Rhamy, November 26, a son, Robert Keith. Mr. Rhamy is a senior in the school of medicine and an assistant in bacteriology.

The Indianapolis and Marion County Medical Society held its regular meeting in the new auditorium of the Indiana University School of Medicine building January 31, the program being contributed by members of the faculty and resident physicians of the University hospitals. Cases of special interest from the hospitals were demonstrated and discussed. Dr. L. H. Allen, chief resident in medicine, presented three cases from the Robert W. Long hospital of encephalitis of the Parkinsonian type, one presenting hereditary multiple exostoses. Dr. Kenneth D. Ayres, chief resident in surgery, presented a case of extensive burns treated by Thiersch grafting. Dr. J. B. Hassberger, chief resident physician of the James Whitcomb Riley Hospital for Children, presented a case of nephrosis, and Dr. James D. George, chief resident physician of the William H. Coleman Hospital for Women, presented a case of ectopic pregnancy. Talks were made by Dr. Harold M. Trusler, assistant in surgery, on disturbances in sodium chloride metabolism; by Dr. E. V. Hahn, instructor in surgery, on sickle cell anemia; by Dr. Thurman B. Rice, associate professor of bacteriology and public health, on ten years of rabies in Indiana, and by Dr. Charles P. Emerson, dean and professor of medicine, on cases of acute hyperthyroidism from the University hospitals.

Memorial tablets removed from the walls of the old medical school building at Senate Avenue and Market Street, recently remodeled for use by the State Board of Health and Highway Commission, have found a safe and honored resting place in the main hallway of the new Indiana University School of Medicine building. One of the tablets is a memorial to the deceased members of the faculty of the Indiana Medical College, and bears the following inscription and names which are held in honored memory by the very large group of Indiana Medical College alumni now practicing in the state and elsewhere:

IN MEMORIUM

Mortuorum arte medicinae clarorum qui intelligentiam prudentiamque ad hominum utilitatem conferentes vitam suam ornaverunt ac se rebus collegii medicini Indianaensis addicentes nomen eius opesque auxerunt.

John Stough Bobbs, M.D.
Geo. Washington Mears, M.D.
Robert Nathaniel Todd, M.D.
Thomas Burgess Harvey, M.D., L.L.D.
John Chambers, A.M., M.D., C.M.
Graham Newell Fitch, M.D.
Elijah Sparks Elder, A.M., M.D.
Charles Edwin Wright, M.D.
Joseph Wilkins Marsee, A.M., M.D.
Philip Schaffner Baker, A.M., M.D.
Evan Hadley, M.D.
John Frank Geis, M.D.
Daniel Augustus Thompson, M.D.
Lehman Herbert Dunning, M.D.
Isaac Clinton Walker, M.D.
William Baldwin Fletcher, M.D.
Franklin William Hays, M.D.

The other tablet bears this inscription:

TO WM. LOMAX
OF EMINENT SERVICE TO
THE MEDICAL PROFESSION
WHOSE BENEFACTIONS TO
THE MEDICAL COLLEGE OF
INDIANA ADDED TO ITS
STRENGTH AND MULTIPLIED
ITS OPPORTUNITIES TO
SUCCESSIVE GENERATIONS
THIS MONUMENT
IN
GRATEFUL MEMORY

WITH an appropriation of $20,000 a year for two years for the library of the School of Medicine granted by the 1927 legislature, Mr. Alan Hendricks and the library committee have been making successful efforts to equip a library adequate to the needs of the medical school and medical profession of the state. Many new books are being purchased and the list of medical journals is being increased. Files of medical journals are

also being completed, which is a rather difficult and tedious task. Space in the main building has been increased for library purposes, with a reading room accommodating about eighty and stock room space for 20,000 volumes.

A special study of chronic arthritis is being undertaken at the Robert W. Long hospital by the department of medicine under the direction of Dr. Charles P. Emerson, dean and professor of medicine. It is suggested to physicians that interesting cases of this type, who are indigent and proper subjects for state care, will be given preference in admissions to the medical wards for a time, in order that a considerable number and variety of clinical material may be available for study.

A considerable amount of unprejudiced data in regard to the indications for and results of various forms of physical therapy, is being accumulated in the Indiana University School of Medicine hospitals, especially in the treatment of joint cases. The number of treatments is running between twenty-five and three hundred a month.

Interest in post-graduate extension courses in medicine, surgery and the specialties, conducted by the Indiana University School of Medicine faculty at the invitation of county or district medical societies, is increasing, according to a report from the office of the dean. Forty-two physicians were present at the opening lecture of a course of eighteen lectures in medicine and surgery begun February 2 at Kendallville for the four northeast counties of the state. Meetings are being held the fourth Thursday in each month. A course of eighteen lectures in medicine, to be followed by a course of the same length in surgery, and in the specialties, was begun in February for the Jasper-Newton County Medical Society. Invitations from other groups have been received and are under consideration. Six lectures were contributed to the program of the Muncie Academy of Medicine, in medicine, last year. Eighteen lectures in medicine were given at Elkhart last year, and also at Madison. Other centers where courses have been given are Terre Haute, Crawsfordsville, and Columbus, at least four counties being served about each center. Courses are now in progress in addition to those mentioned, at Rochester and Seymour.

With the resignation of Dr. John F. Barnhill the sub-department of surgery entitled surgery of the head and neck including the central nervous system has been discontinued and is provided for in the department of general surgery and ear, nose and throat. With the death of Dr. John H. Oliver, head of the department of surgery, and of Dr. Orange G. Pfaff, of the department of gynecology, the department of gynecology has been made more closely a sub-department of surgery, although with its individual organization left intact, it is explained by Dr. Charles P. Emerson, dean of the School of Medicine. Dr. Willis D. Gatch, professor of surgery, as previously announced, has been made head of the department of surgery.

An educational experiment indicating the possibility of a modification of the formal standardization of the medical courses in the United States adopted about twenty years ago, is being undertaken to some degree, with approval of national authorities in medical education, in the Indiana University School of Medicine. Already a pioneer in certain features of training of nurses, dietitians and social service workers, which have since been widely adopted in other medical centers, the local school is trying out the plan of obtaining earlier and better correlation between pre-clinical and clinical courses. The standardized medical course adopted more than twenty years ago and still closely adhered to, rather sharply separated the first two years of the course, which were devoted to preclinical courses and laboratory work, and the last two years of clinical courses. The present tendency, which is being given more of a trial in Indiana than elsewhere, it is said, is to parallel laboratory and clinical courses, helping students to better correlate their clinical observations with what they do for their patients in laboratory tests. Serology, such as the Wassermann reaction, and special pathology will be postponed until the senior year when students will have a better foundation of clinical observations to appreciate the work. Gross pathology will be given the sophomore year, and microscopical pathology in the junior year. Ward rounds, and other clinical work to some degree, will be started with the sophmore year. It is hoped that students will go to their patients without prejudices developed by formal study of text-book types and will be better equipped to interpret their laboratory study in the light of what they actually see manifested in their patients; rather than, as now, trying in many cases, though unconsciously, to make their patients fit ideas they have acquired in preclinical and laboratory work. Results of the experiment, which is being confined to the department of medicine, will be demonstrated at the meeting of the Association of American Medical Colleges in Indianapolis in October, 1928. Dean Emerson, for a number of years a member of the educational committee of this organization, is now a member of the executive committee and Dr. Burton D. Myers, dean of the School of Medicine unit at Bloomington, is a member of the committee on education and pedagogy of the association, which includes in its membership all of the seventy-seven

fully approved Class A medical schools of the United States.

Examination question in obstetrics for senior nurses, training school for nurses of Indiana University School of Medicine, February, 1928, indicate some things a graduate nurse is supposed to know: (1) Explain the following terms and outline the nursing care of each: (A) Phlegmasia alba dolens. (B) Hyperemesis gravidarum. (C) Puerperal fever. (2) Describe the nursing care given to a patient in the first stage of labor. Technique used in vaginal examinations. What precautions are used in catheterization of a woman in active labor? (3) Name three important factors in the care of a premature infant. How would you care for a premature baby in the home? (4) What are the causes of ruptured uterus? Give three early symptoms. Give three later symptoms. (5) What instructions and advice would you give a prenatal case who had had no experience?

At the regular monthly seminar meeting of the Indiana University School of Medicine, February 24, cases from the University hospitals were presented and discussed by Dr. L. H. Allen and Dr. Kenneth D. Ayres, chief residents of the Robert W. Long hospital in medicine and in surgery; by Dr. J. B. Hassberger, chief resident of the James Whitcomb Riley Hospital for Children, and by Dr. James D. George, chief resident of the William H. Coleman Hospital for Women. Dr. Leon K. Zerfas, assistant in medicine, spoke on the importance of recent studies on the capillaries of the body; Lester B. Rhamy, senior assistant in bacteriology, discussed blastomycotic infections, and described a case of pulmonary infection from the Long hospital, and Miss Winifred Conrick, director of occupational therapy in the University hospitals, read a paper on occupational therapy prescriptions, which will be printed in THE JOURNAL. A social hour followed the program. The medical faculty extends an invitation to physicians to feel free to attend these meetings, which are announced in the local papers a day or two beforehand, and have proved quite popular with local physicians.

The newly completed medical building of the Indiana University school of medicine was fully occupied for the first time February 7, at the opening of the second semester, with an enrollment of 305 students in the last three years of the medical course. The new unit, which completes the medical building begun in 1918, provides adequate facilities for the instruction of one hundred students in each of the three upper years. The first year of the medical course is conducted only at Bloomington, where one hundred and fifteen students are enrolled.

In addition to space for teaching laboratories and classrooms, the addition permits expansion of research laboratories, and library facilities. The medical library is being increased from 7,000 to 20,000 volumes, and the number of medical journals available for reference has been increased to include most of the better known publications from all parts of the world.

A feature of the new building of special interest to physicians is the specially equipped auditorium for medical meetings and clinics, with a seating capacity of 425. Here the regular monthly seminars of the school of medicine will be held as well as other medical meetings. Interesting cases from the Indiana University hospitals can be moved in safety and comfort for observation and study by large medical groups. By a ventilation system separate from the rest of the building the atmosphere of the auditorium can be kept fresh and clear even during motion picture and stereopticon demonstrations. This feature was given a satisfactory try-out a short time ago when smoking was permitted with the auditorium filled to capacity at a seminar. Telephones with attendants enable physicians at meetings to keep in touch with their offices.

Administrative offices and a bookstore are located in the new unit, facilitating registration and enrollment of students. Robert Frost Daggett designed the new unit which was built at a cost of $100,000, with proceeds of the sale of the old medical school building at the corner of Senate Avenue and Market Street. Equipment cost an additional $50,000. The building is located with the Indiana University hospitals, the Robert W. Long, James Whitcomb Riley and Coleman hospitals, and the Ball nurses' home and training school, on a thirty-two acre campus in West Michigan Street. The main entrance faces West Michigan Street.

The medical building is the second unit to be added to the Indiana University medical center in a year of development marking the expenditure of approximately $1,000,000, mostly from private gifts. The third unit, the $500,000 Ball nurses' home and training school, will be completed early this spring. With the Long hospital for general medical and surgical cases, the Riley hospital for children and the Coleman hospital for lying-in patients, the Indiana University school of medicine now is able to provide clinical instruction in treatment and care for all types of cases except mental disease, in its own hospitals, and with the aid of the new medical building will be able to increase its direct instructional service to outside physicians.

Seniors in the Indiana University School of Medicine are required to spend two weeks of full-time service attending deliveries on the out-patient obstetrical service of the Indianapolis City hospital. Many physicians of the state who have

had this experience will have memories revived by the following farewell stanzas inscribed by a senior at the close of his service on the wall of the quarters where for two weeks he had been "on call," and occasionally slept. The contributor does not stand sponsor for either sentiments or technique.

"I've delivered my kids where I found them,
I've caught them bare-handed and gloved,
I've smothered my mothers with ether—
And jumped at their bellies and shoved.

One was a sweet young primip'ra,
One was an old para ten,
One was aborted at three months or more,
And one of them 'pregnant again.'

I've been called out at three in the morning
When the pains were a half hour apart,
And the head 'through the brim of the pelvis'
Was not as yet ready to start.

Two waters in breaking have drenched me,
Meconium's mussed up my gown,
And I still have a badly strained shoulder
From helping a mother bear down.

But now, I am through with the service,
And plenty of service I saw—
Twelve normals and three instrumentals,
Five more than required by state law.

No more will my junior awake me
To hurry as fast as I can
To a shack in the dump out at Brightwood
And then have it turn out a 'fan.' "

"Bill" Leslie, '28.

REPORT OF INSPECTIONS OF SCHOOLS OF CHIROPRACTIC IN THE UNITED STATES*

Indiana:

In June, 1927, there were four schools of chiropractic in Indiana, and one school of naturopathy offering chiropractic degrees to those of its students who desired them. The school of naturopathy has been exposed as a diploma mill and closed. One of the schools of chiropractic is reported to have been forced to sell its building, and whether it is now operating in rented quarters elsewhere is not known. Two others were so weak that they may have passed out of existence. The one remaining school is known to be still active.

1. ROSS COLLEGE OF CHIROPRACTIC

This school, after a checkered career in Michigan and Indiana, managed to erect a building for itself at 1311 Webster Street, Fort Wayne. It entered the new building in September, 1926, but is reported to have been forced to sell it in the fall of 1927. Its present address (if it still survives) is unknown.

Of the building (a small two-story brick structure) half of the first floor was used for a business office and the other half for a class room. The second story contained three small clinic rooms (each having four booths and a half-dozen adjusting tables) and another room with some x-ray apparatus and about a dozen chairs.

The school was a kind of family affair, with George O'Neil as president, Helen O'Neil as vice-president, and Nora O'Neil as secretary-treasurer. There were four instructors, none of whom claimed any educational degree except the doctor of chiropractic. There were said to be sixty-five or seventy-five students; the day-class was seen and it contained eleven, their appearance being that of unskilled laborers with their Sunday clothes on.

There were no entrance requirements and no matriculation nor graduation dates; regardless of qualifications, students came and went according to the almanac. There were no laboratories. Clinic patients were to be drummed up by the students themselves and were few in number. Courses were taught by the lecture method and the subjects ranged from pathology and obstetrics to insurance examinations and salesmanship.

The time was eighteen months for the day course and twenty-four months for night. Within that time 3,528 forty-five minute hours were supposed to be "put in" (a practical impossibility), and on the strength of this schedule the American College of Chiropractors has rated the school as "class A." Schools with such a schedule are declared by the American College of Chiropractors to be equal if not superior to the high grade medical schools of America, a statement too ridiculous even to suggest a denial.

2. EVANSVILLE CHIROPRACTIC COLLEGE

This college occupied the third floor of a brick building at 501 Main Street, Evansville, last June, but it had only two students and may long since have ceased to exist. Its faculty consisted of a man and his wife; they lived in one room of the school, and a girl who was evidently a kind of care-taker (perhaps one of the two students) slept in the women's clinic room. About six adjusting tables, six or eight charts, about two dozen chairs and an old desk constituted the school's equipment.

The course was like that of other chiropractic schools. The good doctor and his wife were evidently in a bad way; they offered to make the inspector their official representative and pay him $100.00 cash for every high school student he would enroll for chiropractic study; they would also thoroughly circularize all high schools within a radius of fifty miles of Evansville and would promise not to raise the tuition rate. The inspector expressed his gratitude.

*During the summer and fall of 1927, personal inspections were made of all schools existing in the United States for the teaching of particular methods of treating human disease. This report is a result of the inspections in Indiana.

3. CENTRAL STATES COLLEGE OF CHIROPRACTIC

This school has moved frequently, probably to take advantage of cheap rent. Last June it occupied two rooms on the fourth floor of the Kresge Building, 41 East Washington Street, Indianapolis. The equipment consisted of three adjusting tables, a few students' chairs, and some office furniture. There was a faculty of three, none of whom had any degrees except that of doctor of chiropractic.

There were said to be twenty-five students. They were given a didactic course of twelve or eighteen months (according to the student's prefence), the classes meeting from 7:30 to 10:00 o'clock on five evenings weekly. Twelve months of such a schedule represents 650 clock-hours (but a less number of class-hours) of work, and for this amount of study (with $350) the degree of doctor of chiropractic was awarded.

4. LINCOLN CHIROPRACTIC COLLEGE

This school, when seen, had been in existence about nine months. It occupied the second floor of the new Lumber Insurance Building at 518 North Delaware Street, Indianapolis. There were ten rooms. The equipment was all new and modern. A splendid new filing system had been installed, and a heavy correspondence was being carried on. Besides the school catalog, a small journal was being published. The enthusiasm of youth was everywhere manifest, as if installments and other bills were still being paid when due.

There was a faculty of five, none of whom claimed any educational honors except in chiropractic. The students numbered twenty-five. The clinics were said to have an average of about fifteen patients and to be "building up." There were no laboratories. The equipment consisted of the usual tables, chairs, and desks, with a few charts, a human skeleton, and an x-ray machine.

The courses ran through eighteen months and were said to include 4,095 "class hours" of thirty minutes each. Two diplomas were to be granted every graduate, one in chiropractic and one in "x-ray." This school, with a confessed enrollment of twenty-five, stated in its catalog: "We do not permit the enrollment of more than 125 students in any class. In order that a place may be assured the prospective student should advise us before coming to Indianapolis that we may make reservation for him among that number. If this is not done, it may be impossible for us to accommodate him upon his arrival."

5. COLLEGE OF DRUGLESS PHYSICIANS

This school, primarily a naturopathic diploma mill with headquarters at 215 New York Street, Indianapolis, also conferred degrees in chiropractic (it had obtained the seals of two dead schools of chiropractic) and probably at times gave a brief course of a few weeks' duration. It was exposed in the Indianapolis News on June 24, 1927; the head of the school was arrested and all his records confiscated. The sale of diplomas was frankly confessed.

GENERAL DISCUSSION

The best thing that can be said about such schools as those discussed above is that they usually live but a short time. That the dying ones are replaced by new ones is a deplorable fact. The raid on the late College of Drugless Physicians disclosed the incorporation and purchase of seals for two new schools which had not yet "functioned,"—timely preparation for the day when operations under the old name would be legally forbidden.

The operation of such doctor factories is hard to stop. They usually own no property except a few adjusting tables and chairs. They have no laboratories nor hospital relationships. They risk little except their ability to pay the rent and move if they fail in that. They appeal to "prospects" without even a high school background against which to weigh the merits of their theories. They charge high tuition rates, collect in advance, and leave the student to make the best of the situation. The student gets what he can, keeps his mouth shut, sets himself up as a "doctor" and makes the suffering public pay. The scheme often works. Nearly all chiropractic schools teach salesmanship.

SCHOOLS OF CHIROPRACTIC

CALIFORNIA

Berkeley—Berkeley Chiropractic College, 2618 Shattuck Ave.

Los Angeles—Gale College of Chiropractic, 1406 W. 7th St.

Los Angeles College of Chiropractic, 918-20 W. Venice Blvd.

Ratledge System of Chiropractic Colleges, 2415 S. Western Ave.

Oakland—West Coast Chiropractic College, Inc., 14th St. and 7th Ave.

Pasadena—Pasadena College of Chiropractic, 1608 N. Fair Oaks Ave.

San Diego—Clewell Chiropractic College, 1574 Fourth St.

San Francisco—San Francisco College of Chiropractic, 1067 Market St.

COLORADO

Denver—Colorado Chiropractic University, 14th St. and Cleveland Pl.

DISTRICT OF COLUMBIA

Washington—Chiropractic Research University, 1349 L. St. N. W.

GEORGIA

Atlanta—Atlanta Chiropractic College, 286 W. Peachtree St.

ILLINOIS

Chicago—American University, 34 W. Lake Ave.

National College of Chiropractic, 20 N. Ashland Blvd.

INDIANA

Evansville — Evansville Chiropractic College, Inc., 501 Main St.

Fort Wayne—Ross College of Chiropractic, Inc., 1311 Webster St.

Indianapolis—Central States College of Chiropractic, 412-13 Kresge Bldg., 41 E. Washington St.

Lincoln Chiropractic College, Inc., 518 N. Delaware St.

IOWA

Davenport—Palmer School of Chiropractic, 800-1100 Brady St.

KANSAS

Wichita—Colvin Chiropractic College, 237 S. Main St.

MARYLAND

Baltimore—Maryland College of Chiropractic, 520 N. Charles St.

MINNESOTA

Minneapolis — Minnesota Chiropractic College, Inc., 70 Willow St.

MISSOURI

Kansas City—Chiropractic University, 10th and Campbell Sts.

Cleveland Chiropractic College, 1417 Linwood Blvd.

Western College of Chiropractic, 2021 Independence Ave.

St. Louis—Missouri Chiropractic College, 706 N. Grand Blvd.

NEBRASKA

Lincoln — Nebraska Chiropractic College, Orpheum Bldg., 1134 P St.

NEW YORK

New York—Carver Chiropractic Institute, 71 W. 23rd St.

Columbia Institute of Chiropractic, 111 W. 83rd St.

New York Eastern Institute of Chiropractic, 124 W. 74th St.

Standard School of Chiropractic, 44 Fifth Ave.

OHIO

Akron—Akron College of Chiropractic, 985 E. Market St.

Cleveland—Blodgett Chiropractic College, 565 Rose Bldg., 2062 E. 9th St.

Metropolitan Chiropractic College, Inc., 4501 Prospect Ave.

OKLAHOMA

Oklahoma City—Carver Chiropractic College, 521 W. 9th St.

OREGON

Portland—Pacific Chiropractic College, Inc., 125 N. Grand Ave.

PENNSYLVANIA

Philadelphia—Doughty-Marsh College of Chiropractic, 4201 Walnut St.

National Chiropractic College, 2324 Columbia Ave.

Pittsburgh—Universal Chiropractic College, 1940 Fifth Ave.

TEXAS

San Antonio—Texas Chiropractic College, 602-606 W. Myrtle St.

WASHINGTON

Seattle—Seattle College of Chiropractic, 401-4 Lowman Bldg., 1st Ave. and Cherry St.

REPORT OF INSPECTIONS OF SCHOOLS OF CHIROPRACTIC AND NATUROPATHY IN THE UNITED STATES*

Personal inspections have been made recently of all schools existing in the United States for the teaching of particular methods of treating human diseases. While a complete report of all information secured would hardly be justified, a brief resumé of conditions found in schools of chiropractic and naturopathy will be of interest to both physicians and laymen.

SCHOOLS OF CHIROPRACTIC

Chiropractic is said to have originated in 1895 with D. D. Palmer, a magnetic healer of Davenport, Iowa, and to have been "developed" by his son B. J. It is in reality the older osteopathic concept very slightly modified and renamed. It was the enlarging of the osteopathic field and the lengthening of the osteopathic curriculum that gave chiropractic its opportunity, and the latter's rapid development has been due largely to the fact that it offered a short-cut to osteopathy.

According to this theory disease is due to vertebral subluxations which cause a pinching of spinal nerves between bones. This pinching interferes with the flow of "Innate Intelligence" or vital energy to the body tissues. The spinal "adjustment" alone renews that flow and restores health.

Chiropractic has had, during its brief career of thirty-two years, about one hundred and fifty schools. Forty of these are still active, many of them offering courses at night only and having a mere handful of students; more than half of the forty are so poorly housed and so inadequately financed that their future is problematic. B. J. Palmer, the "developer" of the cult, recently said: "According to our records, forty-eight chiropractic schools have closed their doors during the past two years."[1]

An entrance requirement of four years of high school study or its equivalent is claimed by the best of these forty schools; it is probable, however, that not one of them is enforcing the requirement. Mature age, business experience, ability to carry

*Inspections were made during the summer and fall of 1927, by representatives of the Council on Medical Education and Hospitals of the American Medical Association. The schools included in these inspections are the schools of chiropody, chiropractic, naturopathy, optometry, osteopathy and physical therapy, as well as a large number of miscellaneous institutions.

[1]Article: "The Great Undertow."

the chiropractic courses, or any convenient achievement is declared to be a satisfactory equivalent. A few schools give ridiculously short and easy high school quiz courses and certificates, for which a special tuition fee is charged; this course in one of the best chiropractic schools[2] occupies two evenings weekly for six months. But fifty per cent or more of these schools do not even claim to require a high school education.

The courses offered in the majority of these schools run through "three school-years of six months each." They are poorly chosen, poorly arranged, and very poorly outlined. The student may begin on any school day of the year and finish on the same day of the eighteenth month thereafter. There are no adequate records of amount or quality of work done. Going to school is a matter of "doing time," and the student is given his doctor's degree as soon as the time limit expires. Legislation has forced a few schools to lengthen their courses to twenty-four or twenty-seven months. When this is done, the school usually shortens its working day to three or four hours as compensation, and holds out to the student his ability to spend the remainder of his time earning his expenses. Also, in almost any twenty-four or twenty-seven month school, a student may graduate at the end of eighteen months if he declares his intention to practice in a state requiring only that amount of study. A few schools require less than eighteen months, and one of the most widely known gives only a home-study course that may be finished within three months.

The equipment invariably found in these schools consists of a few adjusting tables, students' chairs, and desks. Some have turned to physical therapy or naturopathy and installed a varying amount of electrical apparatus. A very few have x-ray machines, used (except in one instance[3]) in "spinography." About eight of the forty schools have small chemistry laboratories, with equipment for the very simplest experiments only. Two or three have dissection laboratories. None of the forty schools have laboratories for physics, physiology, physiological chemistry, bacteriology, histology, embryology, or pathology. Courses in these important laboratory subjects are either given by the didactic method or omitted altogether.

The clinics are not adequate for training in the recognition of even the most common disease. There is no adequate apparatus for the diagnosis of such diseases. The treatment procedures taught and practiced do not include the therapeutic measures of demonstrated value, and so the patient is left practically without either diagnosis or treatment. There are no hospitals to which patients in need of hospitalization are referred, and none in which students may study the progress of cases.

The faculties of these forty schools are made up of men of very poor educational qualifications. While a very few are both educated and shrewd, and an occasional doctor of osteopathy or even of medicine may be found among them, the great majority are not trained in any of the "medical sciences," the non-medical sciences, or the liberal art. They are frankly out of sympathy with the organized medical and public health interests, and are openly antagonistic to many of the most universally recognized facts and procedures of civilized life.[4] They circulate, by word of mouth and through the school literature, greatly misleading statements about the chiropractic "profession," ambiguous testimonials concerning the cure of incurables, and wild claims about the schools themselves which a most superficial investigation proves to be without foundation in fact.[5]

3. SCHOOLS OF NATUROPATHY

While a venerable old age is claimed for naturopathy, its development has really been more recent than that of chiropractic; its chief exponent, Benedict Lust of New York, claims that he organized the "parent school" in 1896, but even so ancient an origin as that is improbable.

The cult seems to have no basic idea but to be rather a nature-cure hodge-podge with a decided antipathy to drugs. In fact, naturopathy has developed in part as an effort to broaden the scope of chiropractic. There are about five schools of naturopathy and all of them teach chiropractic. Several of the chiropractic schools teach naturopathy. Probably fifty or even seventy-five per cent of the practicing naturopaths have been recruited from the ranks of chiropractic, and the two cults have always been on the friendliest terms. The chiropractor may easily become a natureopath by taking a three-month "post-graduate" course in one of the naturopathic schools.

Entrance requirements are said to include four years of high school study or its equivalent, but none of the schools of naturopathy really enforce this rule. Records are not kept; the student's word is taken in the matter, and if he is so thoughtless as to confess that he lacks the high school requirement the matter is either forgotten or patched up with as little embarrassment as possible. One schools offers a night course in which the deficiency may be made up (extra tuition being charged for this service), but admits that the requirement has never been enforced.

[2]National College of Chiropractic, Chicago.

[3]The Pasadena College of Chiropractic reports that its students are taught x-ray therapeutics.

[4]For example: Vaccination, typhoid immunization, specific medication, diphtheria, antitoxin, quarantine, focal infection, germ theory of disease, etc., etc.

[5]Thirteen of these schools have made affidavits to the American College of Chiropractors that the curriculum includes 3528 forty-five-minute hours of work, and on the basis of these affidavits have been rated by this "college" as "class A schools" and awarded "diplomas of honor." Allowing for ten-minute intervals between classes and five school days per week, (considering that not a single holiday is allowed during the eighteen months of this course) this schedule would require more than eight hours of actual attendance daily, a program which no school of any nature would attempt to follow. The American College of Chiropractors admits that none of these schools were inspected prior to their being rated and that none of their claims have been investigated since.

The courses run through twenty-four or thirty-six months, with a short school day and an evident carelessness regarding attendance. It is probable that only one school has day classes. These institutions show a marked tendency to have students attending two or more "schools" simultaneously. One school, for example, which claims to operate under about twenty different names, offers "a liberal reduction to students taking four or more courses (schools) at the same time." Another tried to enroll the inspector in two "schools" at once when fifty per cent of the sessions of one conflicted with the sessions of the other. One school counts attendance in each class twice—once for naturopathy and once for chiropractic—and so claims to pile up 6000 class-hours (thirty-minute periods) of study, thus "qualifying" under the new Florida law; this school gives every student two diplomas, and many students three or more, each diploma bearing a different name for the school. No outline of the courses offered is published by any of the schools of naturopathy.

The subjects include sysmotherapy, glucokinesis, zone therapy, physicultopathy, astrological diagnosis, practical sphincterology, phrenological physiology, spectrochrome therapy, iridiagnosis, chiropractic, diet, hydrotherapy, osteopathy, physiotherapy, electrotherapy, mechanotherapy, heliotherapy, tension-therapy, naprapathy, neuropathy, physical culture, and many others.

The equipment in these schools differs little (if at all) from that found in schools of chiropractic, except that a small amount of electrical apparatus is usually found, and adjusting tables are not quite so much in evidence. A small chemistry laboratory is usual; that of the "parent school" in New York has room for two or possibly three students, but has not sufficient equipment for so large a number to perform the same experiments at the same time. There are no laboratories for physics, physiology, physiological chemistry, anatomy, bacteriology, histology, embryology, or pathology.

The clinics are even less adequate than those of the chiropractic schools. No school of naturopathy has a hospital associated. The therapeutic procedures include chiropractic, osteopathy, hydrotherapy, electrotherapy, diet, and a wide range of so-called "natural methods."

The faculties of these schools are composed of untrained men, many of whom have been recruited from the schools of chiropractic. Their educational qualifications are so like those of teachers of chiropractic that no further statement is necessary. That such instructors should train students in the proper use of so wide a variety of therapeutic measures, and do it within the short time allotted, is obviously impossible.

GENERAL DISCUSSION

In such a brief report many matters of interest must be entirely omitted and many others no more than mentioned; elaboration, though a constant temptation, is one which brevity forbids. But to one who is familiar with the elaborate equipment and curriculum found necessary to proper training in the science and art of healing today, the most impressive thing about these naturopathic and chiropractic schools is not what they are, but what they are not. A few statements from this view will properly close the report itself and also form an appropriate prelude to the list of schools following.

1. Of the fifty active schools listed, a few are mere "branches" rather than separately existing institutions, and these fifty constitute less than one-third of the number formerly existing.
2. All but a mere handful of these fifty existing schools are so poorly housed and so inadequately financed that their continuation is problematic.
3. Very few of these schools have even one adequately trained teacher on the faculty, and there are probably less than five expert all-time teachers in the entire lot of fifty institutions.
4. Not one of these schools actually enforces a matriculation requirement of even five minutes of high school study.
5. Not one of the fifty schools gives so much as one worthy laboratory course or has one worthily equipped laboratory.
6. Not one of these schools conducts a clinic in which a wide variety of the common diseases may be studied.
7. There is not one clinic equipped with the trained personnel or the scientific apparatus for the clinical diagnosis of a variety of the common diseases, nor having a laboratory equipped for checking such clinical diagnoses.
8. There is not one clinic equipped for the proper treatment of patients suffering from such diseases.
9. There is not one of these schools whose students or whose faculty may enjoy the privilege of practice or even of observation in any worthy hospital.
10. There is not one of these schools that does not proceed on the basis of unproved theory, ignoring the lack of endorsement by all worthy educational institutions.
11. There is not one of these schools that does not ignore or even avowedly oppose the scientific point of view and the facts of medical science accepted by the authorities of the entire civilized world.
12. There is not one of these schools that does not owe its existence to the fact that it offers a short cut to the practice of medicine.

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EDITORIALS

ETIOLOGY OF CYCLIC VOMITING AND ACIDOSIS IN YOUNG CHILDREN

A good deal of space in medical literature in recent years has been given to the subject of acidosis. It has been held by some that this condition is a clinical entity, brought about by some obscure disruption of the acid alkali balance, giving rise to a set of symptoms which are fairly constant, and yielding to therapy directed toward a re-establishment of a normal balance of the acid alkali ratio. A considerable amount of the discussion is based upon observations of the disturbances in infants and childhood. In view of the fact that the condition frequently is associated with definite abdominal symptoms, including pain, vomiting and intestinal distention, without localization in any particular abdominal area, the question has been raised whether a good many of these are not in fact low grade or relatively mild attacks of infection of the appendix. So-called "cyclic vomiting," in infants or young children, is a condition recognized by pediatricians, and is characterized by recurrent attacks of unexplained vomiting, with the vaguest abdominal symptoms and speedy recovery without serious constitutional effects.

An illuminating case of this kind came under observation. A two-year-old child, who, with its parents, were visiting from a neighboring large city, was taken with an acute gastro-intestinal upset. The pediatrician in attendance was informed by the parents that the condition was similar in all respects to many such attacks which had been diagnosed by a most excellent specialist in the home city as "cyclic vomiting," probably resulting from acidosis. Certain symptoms developed, however, which warned the physician in charge that he was probably dealing with an inflamed appendix. The child was operated, after a stormy scene with the father, and an acutely inflammed appendix removed. The "cyclic vomiting" was cured. The question is of interest because of its bearing on chronic appendicitis in adult life. If it is true that a considerable number of mild but active infections of the appendix occurring in children are labeled acidosis or cyclic vomiting, it would lend strong support to those who contend that every case of chronic appendicitis has been preceded by an acute infection. Be that as it may, enough evidence is at hand to warn us to be suspicious of the appendix as the real cause of these obscure, recurring gastro-intestinal upsets in young children without localizing symptoms.—*M.N.H.*

LATE RESULTS OF OPERATIONS FOR BREAST CANCER

A careful survey of the results of the past two decades of operative treatment for the cure of breast cancer reveals the fact that in the breast, as in other parts of the body, the cure of cancer by operation is not proven by a freedom from local recurrence or metastasis for three or five years, nor yet possibly ten, though the latter limit is, of course, a safer criterion than any shorter time. Until we know more of the etiology of cancer we shall be left to debate whether a reappearance of cancer in an individual who has been free from all signs and symptoms of the disease for as long a period as ten years is not the subject of a reinfection or new activation of potential cancer cells, depending upon what theory of etiology we are willing to accept.

Another debatable question which seems no nearer solution than it did five years ago is the value of radiation, either prophylactic or curative, in the treatment of this baffling disease. While on one side there are radio-therapists quite enthusiastic over their results, and stronger and more powerful apparatus is being devised each year, yet on the other hand some of our best clinicians are not only beginning to doubt the efficacy of this form of treatment but even express themselves as of the opinion that the growth is stimulated and the condition made worse by radio-therapy.

As bearing upon these and some other phases of the problem as it affects the breast, the results of William C. White (Annals of Surgery, November, 1927), in a series of 157 cases, with five operative deaths, are interesting. Some of the conclusions arrived at follow:

The removal of the pectoralis minor is not necessary, nor is the removal of the fascia over the upper recti, though the latter is desirable. Only sufficiently wide excision of skin need be made to avoid recurrence. Definite metastases in the supraclavicular region, or extensive axillary ones, are a contraindication. Of all operable cases thirty to thirty-five per cent are free from recurrence at the end of five years while of those free from axillar metastases sixty to sixty-five per cent are free from recurrence at the end of five years. Of the ten year group of sixty-one cases, twenty-four per cent were free from recurrence at the end of ten years, while of those free from axillary metastasis about fifty per cent may expect to be free from recurrence.

While a study of the morphology and behavior of the breast cancer cell yields some information as to the relative malignancy of this type of cell,

yet such help is not so certain as that derived from a study of lip epithelioma. White is not convinced of the value of pre-operative radiation, nor has the use of this agent post-operatively lowered the mortality in the last half of his ten-year group. However, he has not abandoned the belief that it may do good post-operatively.

A survey of these results brings out one outstanding feature, viz., that it is the early case, the one without metastasis, that offers the best hope of cure, which brings us back to the necessity of eternal vigilance in our propaganda for early medical advice in cancer suspects. Dr. Francis Carter Wood recently has estimated that only about ten per cent of all patients consult the doctor when the cancer is in a curable stage.—*B. P. W.*

DANGERS OF INDISCRIMINATE REMOVAL OF INFECTED TEETH

In our zeal to discover and remove foci of infection as a cause of inflammation in remote parts of the body it is quite possible that many times we are too heroic in our treatment and as a direct result we may stir up local or general infections that may be fatal in their outcome. This was pointed out very forcefully in a paper presented at the last session of the Ohio State Medical Association in which Dr. Richard Dexter, of Cleveland, cited twelve cases in which severe or fatal infections arose following the removal of infected teeth, and in the discussion of the paper several other similar cases were cited. No one denies the importance of abscessed or infected teeth as a focus of infection which may produce general acute or chronic infections, and Billings, Rosenow and others have established definitely the fact that infected teeth may be the forerunner of acute or chronic infection of the joints, in the endocardium, in the kidneys, and in other parts of the body.

Probably every physician has seen one or more instances of almost miraculous amelioration of symptoms of some inflammatory process following the removal of infected teeth. These gratifying results have led, as Dr. Dexter says, to altogether too frequent instances where extraction is ordered without particular study of the individual case and with no thought as to the time or the method of extraction. Thus, in one of the cases cited, an individual, previously in the best of health, died of an overwhelming gangrenous infection of the mouth and face following directly on the removal of two abscessed teeth. In another case, a fatal local and general infection followed the removal of one presumably abscessed tooth. In still another case a number of presumably infected teeth were removed at one sitting. This was followed immediately by a general blood infection which resulted in death six days after extraction. Other cases were cited wherein the local or general infection, following the extraction of infected teeth were extremely grave but not fatal.

While condemning the practice of removing several or all of the teeth at one time, Dexter is of the opinion that the number of teeth removed has little to do with the severity of the resulting infection. The reason for these tragic results of extraction he believes to be due to, first. the surgical technic used for the extraction; and second, the condition of the patient. It is his opinion that given a careful technic, with a minimum of trauma, wherein not more than one or two teeth are taken at a time, no serious results should follow. In those cases in which resistance is lowered by chronic wasting diseases, the removal of infected teeth should be approached with all the judgment and care possible. No teeth should be removed until a careful study of the individual has shown on the one hand that the teeth are a menace, and on the other that the patient is in a condition to withstand such an operation. While Dr. Dexter says that he admits that an abscessed tooth is a potential focus of infection, and that each and every root filled tooth is to be considered as a possible source of infection, and that they should be removed, yet he believes that a warning should be given against the indiscriminate pulling of teeth. Study of the case must precede the decision that the teeth are to be removed, and the extraction must be performed in a gentle and conservative manner to the end that the attempted cure shall not precipitate fatal or serious results. Rough or careless removal of abscessed teeth is fraught with just as great danger to the patient as is roughness or carelessness in any other surgical procedure.

In discussing this paper a physician who has had large experience in the Mayo clinic said that although none of his cases terminated fatally, some of the patients experienced severe reactions following comparatively simple operations on the jaw. These reactions usually were the result of too many extractions at one operation which seldom consisted of more than two or three infected teeth. The number of teeth that safely can be removed at one time is dependent upon the patient's resistance and the condition of the infected teeth. In order to prevent the absorption of large quantities of infection, it is absolutely necessary to remove the teeth with as little trauma as possible. It is his opinion that blindly curretting one tooth socket in the hope of removing a large granuloma will cause a greater reaction in the patient than the careful removal of several badly infected teeth. Likewise, the removal of ankylosed roots with chisel and mallet or with elevators, often will cause a very definite reaction.

Too much emphasis can not be placed upon the importance of carefully removing the focus of infection, and especially in patients with diseases of streptococcic origin, because all infected teeth

harbor streptococci. Dentists seldom know the general condition of their patients and often extract a great many teeth at one time. Although such operations are done in the hope of curing some systemic involvement, the patient often becomes worse instead of better. It seldom is advisable to remove more than one or two teeth at a time, particularly in individuals who are ill. Patients always should be given an opportunity to build up sufficient resistance before further work of cleaning up foci is undertaken. The cases cited should serve as a warning both to dentists and to physicians. The dentist must learn to extract fewer teeth at one operation and with the least possible trauma, while the physician should feel it his duty to advise the dentist of the patient's general condition and of the danger of causing reactions in certain cases. The close co-operation of the two professions is absolutely necessary if patients are to be benefitted.

MAKE A WILL

Every physician should make a will. It is the only way to make sure that the disposition of property after death will be as the physician wished. No physician should attempt to write his own will, for in all probability he would leave loopholes that would thwart his wishes. It may cost a fee to employ a good lawyer, but it will be money well spent. If you leave no will your property will be subject to the laws of the state, and that means the appointment of an executor who may dispose of your property in a way that never would have had your approval. If you make a will it is your privilege to designate who your executor and trustee will be and to say exactly how your property shall be distributed.

The choice of an executor is of considerable importance, and in view of the fact that individuals may die and other individuals not so worthy take their places, it is not a good plan to depend upon individual executors. The trust department of any first class bank is empowered to act as an executor or trustee, and in such instances there is no question about having the provisions of the will carried out in a satisfactory manner. An individual trust officer may die, but there is always some one trained to take his place, and at all events the bank is responsible for the faithful performance of duty and the wishes of the one who has made the will. In other words, as one writer has well stated it, "a financial institution is in a position to give sound advice and bring into play good business training, and, last but not least, institutions of this kind are never ill nor out of town, nor do they take vacations."

Many business men have adopted a custom that could be followed to advantage by physicians, and that consists in not only making a financial institution the executor and trustee of your will but specifying that the bulk of the property is to be wisely invested and the income from it given to the beneficiaries under the law. This insures the protection of the beneficiary from the many pitfalls which present themselves to those who suddenly acquire wealth and may not be able to invest it wisely. The trust officers of any bank are willing to give advice gratuitously to those who may wish to consult them concerning not only the making of a will but the manner of disposing of the various bequests.

"AIN'T GOD GOOD TO INDIANA?"

An Indiana feature writer wrote a poem concerning the beauties and blessings of life in Indiana and every verse closed with the line, "Ain't God Good to Indiana?" The poem was written before one of our governors took up his residence in the federal penitentiary at Atlanta, before our present governor was indicted for an offense that may put him in a penal institution, before the mayor of our principal city of the state was required to furnish a bond to keep himself out of jail, before numerous state officials were proved to be guilty of malfeasance of one kind or another, before the blight of the Ku Klux Klan-ism had ruined the fair reputation of the state, and before many other evidences of crookedness and rascality in the state's public life had come to light. However, there is much evidence to the effect that Indiana is going to clean house, and it is just as well to carry the housecleaning to the remotest corners of our official life, even to deputy constables and deputy assessors. As an evidence of some of the rottenness that exists in Indiana, a highly respected citizen reported an interesting episode to the Rotary Club of Fort Wayne, which is as follows: A stray dog came to the home of a laboring man who had a sick wife and several children to support, and who much of the time was out of work. The dog formed an attachment for the children and remained. A few weeks later a deputy constable asked the laboring man if he had paid dog tax, and upon being informed that no tax had been paid the laboring man was haled into court and fined twenty dollars for not paying the dog tax. When the court was informed that the owner of the dog had no money, and was out of work, a sentence of twenty-days in jail was imposed in lieu of the twenty dollar fine. In reporting the incident to the Rotary Club the business man quoted the sentence which forms the title of this editorial, "Ain't God Good to Indiana?" There are many occurrences of a similar nature occurring in Indiana any one of which is sufficient to make a man with red blood hot with indignation.

THE DOCTOR AS A SUCKER

It is a well known fact that the medical profession presents a most fertile field for exploitation on the part of the promoter of undeveloped and

unrecognized business enterprises, who hopes to enrich himself by the sale of stock to the unwary. Let a well dressed, glibly speaking, polished appearing gentleman offer to sell stock as a favor in a mine, oil well or electric industry to average physicians, with the convincing arguments that this will develop the profits of Standard Oil or the Bell Telephone, and a large proportion of them will at once fall as suckers and swallow the tempting bait without advice of their bankers or approval of their wives. Physicians reading these lines are at the present time paying regular installments for the purchase of stock in enterprises of this sort, who not only will never receive a cent on the investment, but will never again behold the dollars from which they are being so easily separated through their childish confidence in the promoter and his claims. The situation would be a laughable comedy were it not for the tragedy which will later result with the disappointment attending the realization of the fraud which has been perpetrated. This picture is no idle dream but represents the actual experience of many a physician, if he were to confess the innocent credulity with which he has been duped in the past.

This situation could easily be prevented and readily avoided by any physician who would consult his Better Business Bureau, whenever these tempting morsels are dangled before his vision as bait for his consumption. These bureaus exist in most of the large cities, parts of a national organization, established and maintained by the banks and leading commercial houses, whose sole object for existence is investigation and publicity regarding the claims of all concerns offering stock for sale to the public. This information is available for the asking, without cost, on the part of anyone who desires it. If the data concerning a given enterprise are not on file, they will be diligently sought and obtained on short notice. In view of the existence of these bureaus, there is no excuse for a physician to be thus imposed upon and mulcted of his earnings by investments in fraudulent organizations. The next time an eloquent promoter calls at the office, endeavoring to convince you that purchase of stock in certain enterprises will bring returns to comfort and support you in your old age, at once telephone to the Better Business Bureau for information before investing. If the salesman objects to such procedure or grabs his hat and forthwith decamps, it will be at once evident that the proposed inquiry is a profitable one. If, on the other hand, he sits out that investigation, it will be presumptive evidence that there may be virtue in his proposition. Let us quit being suckers and disprove the prevailing belief that as a class we offer the most tempting and attractive prospect to the financial fakir and imposter.—*Northwest Medicine.*

GROUP PRACTICE

Group practice has had its era of popularity and by many observers is said to have failed in fulfilling all that was expected of it. There is no denying the fact that theoretically the enterprise carries the idea that group practice or the clinic give the ailing patient the last word in thorough and trustworthy attention.

However, in practice this does not hold true, for while one or two very notable clinics, where group practice holds forth, have made an unqualified success for themselves, due largely to the dominating personality of one or two men and the inflexible rule of eliminating incompetent or unworthy associates, still in another way the group practice proposition has been more or less of a failure in the majority of instances. This is due primarily to the fact that men hesitate or actually object to losing identity, as they also are not uniformly willing to be molded into a certain groove or niche which they are expected to fill. Differences in temperament has wrecked more than one group, or at least destroyed its usefulness, and, on the other hand, differences in qualifications, ability and personality also have wrecked some of the groups. Not infrequently a man considers himself too good for the group that he is in, or on the other hand, the group finds that one or more of its men are unreliable as to ability if not integrity, and again the group goes to smash. Another feature worthy of mention is the clash concerning the question of compensation, for not infrequently one or more of the men forming a group, even doing a large amount of business, consider that they are not sufficiently paid for the time and ability put into the work. Then again, to increase income there is a tendency on the part of some groups to do a lot of unnecessary work even though it is done on the theory that they are leaving no stone unturned. Therefore, when all is said and done, group practice in its strictest sense is not a howling success in all communities where it has been tried, and it has created the idea among independent physicians, not wholly without truth, that it means the loss of any patient referred to the group as it also has indicated that few groups contain well qualified men throughout, and the latter being the case the patient runs the risk of not having as competent and trustworthy attention as could be obtained in an independent way.

In contra-distinction to the group practice which is represented by a number of associates banded together and utilizing one set of offices or one building and pooling the income, is the equivalent to group practice followed by the great majority of the better men in the profession when referring their patients to various high grade men in independent practice for the expert service that may be needed in throwing additional light upon the diagnosis, prognosis and treatment of the in-

dividual case. Here group practice gives its best results from many standpoints, inasmuch as such outside investigation of the case is given as indicated, and each consultant is selected because of his ability, is paid adequately for the service and no superfluous and unnecessary services are rendered. Furthermore, the referring physician has a chance to retain his personal touch with the patient, which he seldom has when patients are sent to one of the strictly group practice type or the so-called clinic. Last but not least, the better the man the less he will sanction the adoption of a plan that causes him to lose his identity in a very large measure. He works for and he enjoys the independence and reputation that comes from individual effort and he does not like the idea of merging his identity with a group. He also objects to the practice of rank commercialism which seems to be the reputation of so many of the groups that are running independent clinics. This does not indicate that group practice or the so-called clinic is in even a large percentage of cases addicted to commercialism, but there are a sufficient number of clinics that are so rankly commercial as to throw suspicion upon nearly all the rest.

Another complaint concerning group practice or private clinics is that some of them are making a bid for contract practice and in not a few instances at reduced rates. Naturally this creates friction in local medical circles, and it is a practice that has been condemned by the A. M. A. and the constituent medical associations. In fact, contract practice is rather demoralizing, as everyone in the medical profession well knows, for it creates unfair competition for the man in private practice and makes it more or less impossible to secure adequate fees for any work. It is quite possible, with the lowering of the economic standards of the medical profession, due to increasing development of paternalism in medicine brought about by the free clinics under federal, state, municipal or philanthropic control, that contract practice will continue to be popular in industrial communities in particular, and it may be that changing conditions will make group practice for the private clinics a means of self-preservation, but we are inclined to believe that the medical profession as a whole ought to see "the handwriting on the wall" and encourage more independence on the part of the individual physician and discourage all of those measures which tend to place the physician in the position of being a very small and insignificant cog in a big wheel.

BROADCASTING BUNCOMBE

Whatever else may be said of the quack and the faddist, they must be given credit for enterprise. The sheet anchor of the dispenser of pseudo-medical buncombe, no less than of the out-and-out quack, is publicity. In the not very distant past, the quack and the faddist had the entrèe—at advertising rates—to the majority of the newspapers of the country, and thus was made the point of contact between sucker and suckee. But gradually public opinion forced at least the better class of newspapers to be more circumspect in the space that they sold to those who offered panaceas for human ailments, and today the majority of newspapers of wide circulation do not cater to the business of the medical faddist or the quack. With that avenue closed, it became necessary for these gentry to seek other fields of publicity, and it was but natural that they should turn to the latest wonder of modern science, wireless telephony—the radio. This field had three elements in its favor: first, its novelty; second, the fact that the spoken word is even more effective than the written word in carrying conviction; third, and most important, that the business of broadcasting is in its infancy and its code of ethics is naturally low.

Broadcasting in the United States is a commercial venture. Generally speaking, the broadcasting station is out to sell time on the air, just as the newspaper is out to sell space on paper. It is natural, therefore, that these stations should look with favor on any commercial organization that is willing to pay the price the station asks for puffing its particular line of goods. Thus it is that we who are radio fans have our ears assailed almost nightly with some pseudo-medical fad, or the exploitation of some crude piece of quackery. One of the earliest entrants into this field was the "Palmer School of Chiropractic," which has its own broadcasting station, WOC, at Davenport, Iowa, whose programs, unobjectionable in themselves, keep before the radio listener the fact that there is an alleged educational institution devoted to the "science" of backpushing. Then there is that enterprising quack who specializes on "rejuvenation" operations and who practices, apparently, without let or hindrance by the state authorities, from Milford, Kansas—John R. Brinkley, who owns and operates KFKB. Station WHT some months ago was broadcasting with great regularity the alleged virtues of a "patent medicine," Salicon, a preparation that the A. M. A. Laboratory found to be essentially a mixture of 3 grains of aspirin and 2 grains of magnesium carbonate. WJAZ, not so long since, was telling the radio world the marvels of that ingenious faker Professor Scholder, who professes to grow hair on bald heads, but who was unable to differentiate dyed twine from human hair. Over KTNT of Muscatine, Iowa, comes the story of the "Tangley Institute," which has a sure-fire cure for varicose veins, the invention, it appears, one of Dr. Charles L. Barewald of Davenport. WJBT of Chicago has described, via the ether, the marvels and virtues of the magic horse collar, the "I-on-a-co," of quack Wilshire. The Voice of Labor—WCFL—permits Dr. Percy Lemon Clark of Chicago,

"a world authority on dietetics and food combinations," to broadcast health misinformation. Clark operates a "Health School" on "Santology" and tells the world that "acidosis and toxicosis are the two basic causes of all disease." Over this same station—WCFL—comes also the "Restoro," a base imitation of Wilshire's magic horse collar, and possessing as much therapeutic value as an empty tomato can with a string tied to it.

Some day possibly the broadcasting business will grow up, and when that time arrives, it is to be hoped that it will have adopted a code of ethics at least as high as that of the average newspaper. —*Jour. A. M. A.*, Nov. 19, 1927.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

County Medical Society Secretaries: Make your plans *now* to attend the Secretaries' Conference in Indianapolis, April 26th.

Those notoriety and money-seeking authors who are besmirching the reputations of Washington, Lincoln, Harding and other statesmen who have gone to the great beyond, deserve and should receive the condemnation of all right-thinking people. No one but a coward attacks those unable to defend themselves. Human frailties are common with us all and nothing is to be gained by dragging our great men of the past through the mud and mire of scandal.

It is a little amusing to have some rather obscure medical writer who has had an article accepted by one of the leading medical journals of the country seize upon the opportunity to advertise himself by preparing abstracts of his paper and not only sending the same to all of the medical journals of the United States but to a very large number of individual physicians on the assumption that they are interested in the particular subject discussed. We suppose that would be considered ethical advertising, but really we think that it is pure exploitation of the author and in bad taste.

Dr. George Walker, a Baltimore scientist, formerly connected with Johns Hopkins University, has been doing research work in connection with the cause and cure of cancer. He announces that in order for an animal to develop cancer it must have a special kind of tissue, and that in order for this special kind of tissue to change into a cancer this special tissue must have a prolonged contact with some external and internal chemical agent or agents. He believes that these chemical substances will be isolated and thus the problem of cause and prevention of cancer established. In his experiments with rats he has proved a statement generally accepted that cancer is noncontagious, and the ordinary contact necessitated by the care of a patient suffering with cancer is not in the slightest degree dangerous.

The First Annual Springtime Conference and get-together of the county society secretaries will be held Thursday, April 28, in Indianapolis. A general round-table discussion will be the feature of the meeting. The secretaries' committee is working on the program and detailed announcements will be sent to each society secretary as soon as completed. Dr. J. C. Burkle, M.D., of Lafayette, chairman of the Secretaries Committee, will appreciate any suggestions you may have to make. He urges that *every* secretary be present at this conference and bring your problems with you for discussion. Have you a practicing physician in your county who is not a member of your county society? If so, why? What kind of programs are you presenting? Do they please the members? Do you invite other professional members to your meetings? These and many other questions will be discussed.

The sanatorium of the Jewish Consumptive's Relief Society is said to be the largest strictly free sanatorium for tuberculosis in the world supported entirely by voluntary contributions. The institution cares for three hundred patients, both Jewish and non-Jewish, though the funds at all times are insufficient to meet urgent needs, and in consequence an appeal is made to the generous who may be inclined to help such a worthy cause. The institution is located at Sanatorium, Colorado. As a passing comment we desire to say that the Jewish people as a people take care of their own in sickness, death and distress. It is claimed, and probably with justification, that no charitable institution kept up by taxation has a Jewish inmate, which fact is not only a tribute to the thrift and industry of the Jewish people as a class, but to the liberality with which welfare work for the unfortunates is supported.

A Physcian speaking before the Physician's Fellowship Club in Chicago said that the dreams of our waking hours determine our earthly activities, our failures, our triumphs, our contributions to the weal or woe of our coming genera-

tions. He also says that the dreams of our sleeping hours are will-of-the-wisps, of small import to the normal mind. He might have added that it applies equally well to those of abnormal mind, and when you talk about a normal mind—just what is a normal mind, anyway? Wouldn't each and every one of us be considered to have a mind that is a little abnormal if it comes right down to a strict analysis? Anyway, we are of the opinion that the psychology of dreams has no practical importance, and we are convinced that some of those who are preaching differently are about as mentally unbalanced as those dreamers who are being studied and their dreams being classified.

IT is said that the president-elect of the Kentucky State Medical Society has entire charge of the scientific program for the annual session, and is responsible for it. We don't believe that such a plan would work in Indiana at all, for the success of any program depends very largely upon the enterprise, ability and activity put forth by those responsible for it, and there is a wide difference in the capacity of individual men. It seems to us that our plan of having the program in the hands of a committee representing the officers of the association and the officers of the various sections of the association, is perhaps the best plan to follow. Very naturally, the president is interested in having the convention at which he presides successful from every point of view, and to that end he will lend his influence and advice in preparing the program, but we do not believe that he should shoulder the entire responsibility and be held accountable.

IF anyone thinks that the Christian Scientists have a mortgage on the publicity stunt, he or she has another guess coming, for the Mayo clinic indulges in much ethical advertising and secures much publicity of an ethical kind. Sometimes they are paying for it, but occasionally they receive pay for it. We have known a lot of fellows in the medical profession to be called on the carpet for acts less flagrant than some of those practiced by the Mayo clinic. However, in defense of what has been complained of by a great many physicians, we believe that the publicity given the Mayo clinic is in reality an educational feature for a very large number of medical men who profit by detailed and comprehensive reports of the work done. It is quite true that the clinic, and even individual members of the clinic, receives an abundance of gratuitous and complimentary advertising in the lay press which is not sought and for which sanction is not given, but that in any vocation is a penalty for greatness.

JOHNS HOPKINS UNIVERSITY has received a donation of $190,000 to be used for experimental work in an effort to discover a cure for the common cold which affects about one-third of the population during the winter months and often lays the foundation for serious if not fatal complications. Here's hoping that something may be accomplished that really will prove beneficial. However, in passing it may be well to remember that a common cold is but the stimulation to activity of infection already existing in the body or acquired from outside sources, which becomes active through a lowered resisting power or the existence of suitable conditions for its development. Perhaps some means of destroying the infection rapidly may be discovered, but another field for investigation will be the means for increasing the resisting power of the individual. The subject offers a field for investigation which perhaps the donation to which we have referred may aid materially in arriving at conclusions of more value than those accepted at the present time.

THE Massachusetts General Hospital at Boston has a pay consultation clinic which was started on July 1 last year. Patients are admitted by appointment only, and through recommendation of a regular physician a letter from whom is required in every case. The letter is supposed to state the nature of the patient's complaint and the special examination required. No treatment is given. Some of the established fees are as follows: Consultation, $10.00, x-ray, $3.00 to $10; laboratory examination, $2.00; cystoscopy, $3; electrocardiogram, $2.00; metabolism, $3. On the face of it this seems to be a very desirable feature and one that should do away with much of the imposition upon the hospital practiced by some physicians who have the habit of referring pay patients to a free clinic. On the other hand, it does give patients an opportunity of securing the assistance of a trustworthy clinic by paying a reasonable fee for it, and at the same time the results of the consultation and opinion given oftentimes help the general physician who is in charge of the case.

WE are through with all of this bunk connected with the publication of hotel rates in cities where medical conventions are to be held. It may look well in print to see the announcement of a well known hotel to the effect that minimum rates will be three dollars for a single room with bath and five dollars for a double room with bath, but when you try to secure such accommodations you generally find that there "ain't no such animal." We know for we have tried, and though we started well in advance it was an impossibility to get anything under about double what had been advertised as the minimum rate. Therefore, we have come to the conclusion that if we publish

any more hotel rates it will be with the distinct announcement that rates for certain accommodations are not to exceed a certain amount, and then he who reads may be guided accordingly. When physicians attend medical conventions it is a good plan to engage hotel accommodations well in advance and have an acknowledgment from the hotel as to just what accommodations are to be furnished and the exact price to be paid for the same.

In a radio talk given by the sanitary engineer of the New York State Department of Health, on the subject of heating and ventilating for comfort, a plea was made for more moisture in the air as an essential in the modern home. By inference he condemns the weather stripping for doors and windows on the ground that the leakage of air around doors and windows provides sufficient circulation except in those rooms which may be occupied by a considerable number of people, in which latter case it is advisable to slightly raise the lower window sashes beneath which radiators are located. Americans have the habit of living in over-heated houses. A temperature of sixty-eight degrees is quite sufficient for comfort if the occupants of the home are clothed properly. Water placed under or around the radiator is almost a necessity to furnish sufficient moisture. Potted plants liberate relatively large quantities of moisture and are valuable adjuncts in making the air of homes more comfortable. He concluded by saying that dry air often will chill the body even when the thermometer is relatively high. Keep the air in your homes moist enough and you will be more comfortable with less heat.

Recently a man in Michigan was convicted of possessing a pint of gin and sentenced to life imprisonment under Michigan's new criminal code which provides life sentences for persons convicted a fourth time for felony. Isn't that a fine example of justice in this land of the free and home of the brave? Presumably, Michigan's law covering this point was intended to apply to the habitual criminal on the ground that he is dangerous if he has his liberty. That isn't correct theoretically, and as a practical application of it, it is tyranny. Fortunately the attorney for the Liberty League of America, residing in New York City, will appeal the case to a Federal court where it is hoped that such an idiotic and inconsistent law will be set aside. In commenting on the case the attorney says that the Michigan law concerning this matter is the most severe in the United States, and the only approach to it is the law in Indiana barring the use of liquor in medicinal cases. To what are we coming anyway? This is a pretty good country, and we are for it on the whole and are quite willing to stand out and wave the Stars and Stripes, but once in a while an episode like this makes one feel that he would like to bite his own grandmother.

A Writer in *Southern Medicine and Surgery,* in reporting on a study of tuberculosis in over seven thousand school children, says that every child who has suspicious symptoms of tuberculosis should be given the tuberculin test. If it is negative tuberculosis can be ruled out; if it is positive the child should be given the benefit of all available diagnostic procedures to determine whether or not clinical tuberculosis is present. There are no characteristic symptoms of childhood tuberculosis. The symptoms more frequently found are under-nourishment, though actual loss of weight is rather unusual whereas a failure to grow and gain weight is rather common. Fatigue or tiredness is frequent. There is lack of energy, and a tendency to avoid forms of amusement requiring much exertion. There is a tendency to nervousness, or to be feverish and irritable. Delayed recovery from other diseases such as measles, whooping cough, or influenza without any other complication to explain the delay. Fever may or may not be present. Variations in temperature in children are common anyway. Consequently, fever is of much less diagnostic significance than in adults. Diseased tonsils and adenoid tissue may produce some of these symptoms and should not be overlooked.

At a medical banquet a short time ago the following story was told: An Indiana physician who was not feeling very well frequently took a sip of medicine which he carried in an unlabeled bottle in his pocket. An inquisitive old hen of a woman who happened to see these frequent sips at the bottle became suspicious and finally had the nerve to ask the doctor what he was drinking. Thinking to have a joke on the inquisitor, he said that he was trying to get rid of some gin he had on hand. The woman happened to be a staunch temperance advocate and she considered it her moral duty to report the matter to the prohibition officer. A search warrant was issued and the doctor's office was invaded with the characteristic disrespectful attitude assumed by prohibition officers, but nothing incriminating was found, even though the various bottles in the drug room were carefully inspected and odor-analyzed. When about to leave it was suggested by the doctor that the prohibition officer ought to find something for his trouble and perhaps he would be satisfied with a bottle of radiator alcohol that apparently had been overlooked. The lesson to be learned is that while in Indiana you must be careful as to when and where you take anything out of a bottle and who sees you do it.

Christian Scientists have the finest press-agency in the world. Furthermore, they get more

propaganda in lay publications without paying anything for it than any other organization or for that matter any commercial enterprise. For the ring-leaders Christian Science is a business. They seem to get advertising in the lay press gratuitously on the assumption that the business is a religion. Whenever a lecturer from the mother church in Boston goes out on a lecture tour throughout the country it is a safe bet that every lecture will be published in full in the lay press. One of the gems, taken from the address of one of these lecturers who haled from Boston, is as follows: "There is no condition of moral, mental or physical distress which cannot be healed through the application of the teachings of Christian Science." Aside from the fact that such a statement is very largely falsehood, and criminally false as it pertains to some forms of physical distress, it is dangerous propaganda and ought to be suppressed. Just as long as Christian Science parades itself as a religion pure and simple, we have no comment to offer, but when it is paraded as a cure-all for any and all diseases, which perforce must include diphtheria, scarlet fever, small pox, typhoid fever, infantile paralysis, and in fact dozens of serious diseases, injuries or deformities, then we object. As the old Dutchman says, "Enough is enough."

WE have learned through trustworthy sources that a health officer in one of our populous cities outside of Indiana has been making considerable money by incorporating in his health talks, published in the daily and weekly papers, a recommendation of various merchandise that either directly or remotely pertains to health. In order to have no slip-up in the receipt of compensation he submits his health article containing the recommendations for some particular merchandise and collects the fee in advance from those who are to profit by the sale of the merchandise. No fee, no recommendation. It is said that one single health article published rather widely by the newspapers contained three distinct recommendations concerning different types of merchandise, and each recommendation netted the health officer one thousand dollars. Such conduct is unbecoming a trustworthy physician, and is inexcusable in one whose opinions are given so much weight by a considerable part of the laity. Presumably the health officer in question is a part and parcel of an official family that profits by graft and he has decided to get his share while the getting is good. However, such a grafter should be kicked out of office, as he also should be kicked out of respectable medical societies. Whenever a physician's opinion can be shaped to fit a fee, it is time to place that physician in the list of persons who cannot be trusted for anything.

WE have been interested in hearing several persons say that within the last few months they have been examined for life insurance and given such a superficial and cursory examination as to make the procedure practically worthless. In fact, they really were passed as good risks without the examiners knowing that some insidious or chronic disease might be present and cause any good insurance company to refuse the risk. It is such life insurance examinations that discredit examination as a requirement and leads companies to write group insurance without examination. Some insurance companies go so far as to say that group insurance is just as safe for the insurance company and can be written at rates less than the rates for insurance for individuals under the examination plan. All of which leads us to say that our argument, advanced in THE JOURNAL on more than one occasion, is correct, that premiums can be reduced materially by any company that has the good sense to secure *trustworthy* life insurance examinations from medical men, who are selected with more discrimination, and that accepts no risks that are not definitely passed by the examiners. At present the good risks are penalized as a direct result of insurance given to the bad risks, and our contention is that no insurance companies at the present time are able through the system now in vogue to eliminate the bad risks, though it is quite possible to do so if they will make radical changes in their system.

JUST where are we drifting in this effort to build more and larger medical centers, with the expenditure of millions for hospitals, dispensaries and buildings devoted to welfare work? What is to become of our young doctors when these medical centers with their wonderful facilities and almost unlimited means for maintenance and expansion are in full operation, with the opportunities afforded for almost unbounded free service to all who come? We have been laughed at when we suggested that for a long time we have been drifting toward state medicine, but those who formerly doubted the possibility of having any such parental service afforded the American people in connection with their physical ills are beginning to change their tune and look with alarm upon the growing flood of what virtually is state medicine and will continue to be more so as time passes. We believe, as we always have believed, that state medicine will not be to the best interests of the public, for it is a kind of paternalism that destroys independence as well as initiative, and does not make for the best service. For the medical profession as a profession it spells destruction, but the medical profession is responsible for it. We are even encouraging it, so why worry? If physicians prefer clerical positions, and laugh at independence, they ought to have what they want. Certainly they are headed for a bureaucracy under federal, state and municipal control, with now and then a salaried position under some welfare organization. It's a fine prospect!

Some of the undertakers of Indiana are voicing a very definite and justifiable complaint concerning not only unnecessary postmortem examinations but mutilation of bodies to such an extent that embalming or preservation is entirely out of the question. In the effort to standardize our hospitals and presumably make the service more efficient there is an attempt being made to have more postmortems, and it is the boast of one of the hospitals in Indiana that fully seventy-five percent of their deaths are subjected to necropsy. There is no question about the advantage of a postmortem examination in rare cases or those dying from obscure lesions, but we believe that altogether too often such examinations are held when there is no good and sufficient reason for it. The results of such indiscriminate necropsies has called forth protest from not only the undertakers but from the public as well. We believe that the protest should be a warning to hospital authorities and members of the attending staffs of hospitals to recommend postmortem examinations only in those cases where it seems indicated in the best interests of science. Indiscriminate postmortem examinations are unnecessary and unjustifiable. If the practice continues it is a safe bet that someone will introduce a bill in the legislature and get it passed and enacted into a law putting restrictions around postmortem examinations that will seriously hamper the work of the medical profession in its effort to study disease through necropsy findings.

There are a few physicians who are so inconsistent and irrational that they do not recognize the dangers of recommending to their patients the services of certain mechanotherapists who never have had any medical training, and opticians or optometrists who know nothing about eye diseases and little more about the proper correction of optical defects. Is it any wonder that their patients often leave them and consult the quacks and pseudo-medical cults when they find that the family physician is so careless in his recommendations of those from whom to secure services for illness or defects of any kind? Perhaps the jeweler, optician or optometrist can correct the simpler errors of refraction, or occasionally hit upon a more complicated correction that serves satisfactorily, but how are they to know that the errors are simple or that an error alone is accountable for the trouble which causes the patient to seek relief? The general theory that presbyopia or old-sight is easy to correct has led many patients of middle or advanced life to accept services from a non-medical man when securing glasses, when the existence of a simple glaucoma or some other serious intraocular affection has been left to play its serious part in the production of great impairment of vision or even blindness through neglect in having it treated. The penalty is too great to justify taking the chance, and while laymen may choose to play with fire there is no reason why physicians should do so themselves, or recommend patients to do so.

Despite all propaganda widely distributed throughout the state over a series of years, and despite all legal enactments concerning the prevention of ophthalmia neonatorum, we still hear of the disease in the practice of not a few physicians in Indiana and occasionally a resulting case of blindness that could have been averted had the physician used appropriate preventive measures. Recently we have heard of a physician who while not a graduate of a regular medical school is a member of a regular medical society, who disclaimed the efficacy of Crede's method as a preventive of ophthalmia neonatorum, and in consequence he has been responsible for not only an attitude that has made it possible for the development of gonorrheal ophthalmia in a newborn babe through no effort to suppress it, but following the development of the disease his lack of intelligence and efficiency in the treatment of it has ended in the blindness of the babe. In reality such ignorance and inefficiency deserves not only a reprimand but punishment at the hands of our medical societies, even if the law does not take its due course. Every newborn babe should be subjected to Crede's preventive treatment, which consists in having two percent nitrate of silver solution instilled in the eyes at birth. It makes no difference what the social or religious standing of the famly may be, this preventive treatment should be utilized. There are altogether too many persons who have been blinded for life through the neglect of a one-minute precautionary measure at birth. We have neither sympathy nor respect for the physician who is guilty of this neglect.

Several months ago we commented on the criticism of a young married woman who was a maternity case in a hospital and objected to the presence of several interns and nurses while she was being delivered. The complaint came from Fort Wayne, but now we hear of a similar complaint from Indianapolis, and it was a vigorous protest against the lack of regard for the patient's modesty and finer sensibilities by the attending physicians, who seemed to have thought that an obstetrical case, even though a private patient and paying the regulation fees, could be used for exhibition purposes for the benefit of students and interns. The young woman says that her mother had nine babies at home without the slightest complication and with about one-quarter of the expense that a confinement case in the hospital costs nowadays. She also says that when she has any more babies she will have them in her own home, where she will not be subjected to exhibition purposes, and where the only attendants will be the obstetrician and the nurse.

We believe that this young woman's complaint is justified, and perhaps while her experience during confinement is the exception rather than the rule yet we do know that there are altogether too many physicians who are "case-hardened" and so steeped in the practical side of the practice of medicine that they overlook, in a measure, the sensibilities of some of their patients. It is not false modesty that prompts a woman to object to exhibition purposes for students, interns and nurses. God forbid that women should lose all sense of modesty, and the average woman of refinement does object to a physician's disregard of her feelings.

A MOTOR truck manufacturing company is sending to truck drivers a sticker, to be placed on the windshield of the truck, which reads, "This driver will meet all other gentlemen half way on any traffic situation." The supposition that all truck drivers are gentlemen makes us laugh, but while we are laughing we are reminded that many drivers of motor vehicles of various kinds cannot be classed as gentlemen if judged by their actions while driving on public highway. It is very amusing to note that your neighbor, who is a fine fellow to meet socially and in most every way is a desirable citizen and neighbor, is very apt to be arrogant, selfish and inconsiderate of the rights or comforts of others when he gets into his automobile and goes out on the highways and byways. Just why driving an automobile should make a fool of a man is a psychological problem hard to solve, and especially when the driver seems to be sane and sensible on any other topic and in any other situation. However, we are disposed to think that a little education goes a long way toward helping to smooth out the roughness of the automobilist's road and the matter of extending and receiving courteous treatment. We believe that the sticker already mentioned may help some. Incidentally, we have noted that the "road-hog" and the inconsiderate automobile driver is not encountered so frequently since most of our main highways of travel are paved with concrete. Our sympathy goes out to the automobilist who objects to giving half of the road to a wild and reckless driver who wants to get by and then makes you eat dirt for the next five miles. Good roads are creating more courtesy and consideration of the rights and comforts of others in automobile driving than any other one thing.

"PUBLIC health and hygiene are in danger because zealots—trained and untrained—are advocating a hundred new health rules a year." Dr. Thurman B. Rice of the Indiana University School of Medicine charged in his address to food and drug experts attending the 56th annual meeting of the American Public Health association in Cincinnati recently.

"The subject of vitamines has been ridden too hard by the laity and a large part of the profession," said Dr. Rice.

"In our enthusiasm over vitamines and a well-balanced meal we must realize that the busy housewife cannot memorize a vitamin table nor can we expect her to wrestle with a problem that would stump a professor of bio-chemistry. Both phases of nutrition can be taught simply and in a common-sense way.

"My objection to excessive attention to calories is akin to my deep seated aversion to all methods of attempting to standardize the human being.

"The dining table is not to be made a prescription counter.

"Patients with metabolic diseases, or in danger of such, must consider their calories, as do those who are really too fat or too lean—but, for the rest of us less mathematics and more leisure, for work or play, will be appreciated! When my wife begins counting my calories, I am going to start dining out. If she serves more than I want it is my right as an untrammeled American freeman to leave it on my plate; if she serves too little—well, there is the fruit stand, the candy counter, the soda fountain, and even the cafeteria across the street."

His menu for a model breakfast for the growing child, prepared in a few minutes, follows, "fresh fruit, buttered toast, cereal with cream or milk, cocoa made with milk, bacon or an egg, an attractive dining room and a smile from dad and mother."

"The most important ingredient in a child's well balanced ration is an intelligent, happy, healthy mother," Dr. Rice emphasized.—*Honolulu Star Bulletin,* Feb. 16, 1928.

WE believe that a majority of the newspapers here in Indiana would be willing and some of them would even court the opportunity to publish a health column under the auspices of the Indiana State Medical Association or even the Indiana University School of Medicine. Such a column should be open for the dissemination of trustworthy information concerning disease and its prevention, and it should be open to questions from readers concerning any medical problem upon which an intelligent opinion may be passed. Very naturally many questions would be asked which could not be answered without an examination of the patient, and it should not be the function of a department such as mentioned to prescribe for individual cases or take the place of any general physician or specialist. The whole idea of a department on health would be to preach the doctrine of health preservation and direct people in a sane and rational line of action concerning their illnesses. We have an idea that such a department when sponsored by such an organization as the Indiana State Medical Association would serve a very useful purpose and be

appreciated by the public at large. It would offset much of the purely personal fads and foibles of individuals who now are conducting health departments in lay papers, even though on the whole such departments are trustworthy, and it certainly would offset much of the vicious and dangerous teaching of quacks and charlatans which now finds a place in the lay press. Such an enterprise is contemplated in several of the states, and Indiana could well afford to be one of the leaders in this progressive movement. To put the plan in operation would require the selection of a committee of representative men to pass judgment upon everything that is published, even to answers to inquirers, and to maintain the enterprise an appropriation of money would have to be made to pay expenses. However, the Association can well afford to make an appropriation for such an enterprise. Perhaps even the newspapers that would profit by securing much "copy," would be quite willing to help to pay some of the expenses of keeping up such an activity.

Of all the idiotic and asinine rulings concerning our methods of assessing taxes, we put the medal on the one that requires physicians to list their bills receivable for taxation. It is bad enough to tax unmercifully something you already own without taxing something you do not own and may never get. It is poor comfort to be told that you can offset your bills receivable by bills payable, for in the one case the bills receivable may mean a loss of anywhere from twenty-five to seventy-five per cent, whereas the physician who meets his obligations generally has few bills payable and those are worth one hundred cents on the dollar. Furthermore, to be told by a tax assessor, as actually has happened, that physicians are going to be required to keep a complete set of books such as used in any mercantile business and which must be audited for trial balance at the end of each year, is laying the law down with a vengeance.

Concerning this question of taxation, we are disposed to ask "where are we heading anyway?" Already we are penalized heavily for frugality as well as enterprise, and we are so taxed by federal, state and municipal authorities that accumulation "for a rainy day" becomes almost an impossibility. Then, to add insult to injury, we are obliged to sit back and watch the riotious expenditure of funds raised by taxation and the criminal carelessness with which funds are handled by many public officials. There is no such thing as "government by the people and for the people" in the matter of taxation and the expenditure of public funds. Men go into public office with fine promises of relief to a long-suffering public, but the minute the office is taken the promises are forgotten. If the worm turns, look out! There is evidence that the voter, already the goat, is going to awaken from his lethargy and get busy in stamping out the exploiters and grafters in public life.

The physicians in Texas believe in doing things! Through their state medical association they are advertising to the public concerning the qualifications of a physician who can be trusted. They have no hesitation in pointing out the inefficiency and ignorance of the members of the pseudo-medical cults. They also feel that it is necessary to take a hand in politics, and accordingly they maintain a sort of political bureau which notifies the individual physician concerning all political matters which may come up for legislative action, and upon which the approval or rejection of medical men should be sought. In fact, so influential is the political bureau that politicians invariably consult the bureau before going ahead with any radical plans pertaining to any legislation that is even remotely of interest to medical men. Then the Texas medical men believe that it is up to them to help in the prosecution of medical offenders, and to that end a sort of detective is employed by the association to keep tab on evil-doers and procure evidence that may be necessary in the successful prosecution of an individual case. In other words, the Board of Medical Registration and Examination has the actual support of the State Medical Association. This all takes money, but the medical association makes a sufficient appropriation for it, and this, together with ample funds at the command of the Board, is quite sufficient to make it warm for all evil-doers in Texas. This is quite different than it is in Indiana where even the fees collected by the Board of Medical Registration and Examination are in part diverted to the general fund, perhaps to be used in paving roads, or to pay for the junketing trips of state officers. It is rather surprising that our Board of Medical Registration and Examination is able to effect as much as it does in consideration of the fact that they have little or no funds with which to prosecute offenders. It would seem that our legislature is inconsistent in thinking that a law can be placed on the statute books and no money furnished for enforcing that law. However, it is doubtful if all of the money spent in enforcing the medical practice acts in Texas accomplish any more than we accomplish right here in Indiana as a direct result of the eternal vigilance and the fidelity of the members of our Board who are quite willing to make personal sacrifices in order to fulfill the duties of office.

In Memoriam



CHARLES GORDON BEALL, M.D.

Dr. Charles Gordon Beall, one of the leading internists of Fort Wayne and northern Indiana, died February 7, 1928, from a bronchopneumonia of short duration.

Born in Fort Wayne October 1, 1881, Dr. Beall was a product of the public schools of that city, graduating from its high school in 1900. He then entered the Fort Wayne College of Medicine, from which he was graduated with honors in 1904. Following a year's internship at the Indiana School for Feeble-Minded Youth, he completed an externship in obstetrics at Dr. Joseph B. DeLee's dispensary in Chicago, after which he spent a short time in general practice in Oklahoma City, Oklahoma. He was then recalled to the Indiana School for Feeble-Minded Youths as resident physician which position he served faithfully for three years, though he remained consulting physician to that institution for many years after entering private practice. In 1911 he spent six months in Germany, pursuing diagnosis and internal medicine, and upon his return resumed general practice which he followed until his enlistment as a lieutenant in the U. S. Army in February, 1918, when he was ordered to Camp Pike. In September, 1918, he was sent overseas serving as captain in the American Army in France. He returned in April, 1919, and at once limited his practice to office, hospital and consultation work.

Dr. Beall was an invaluable member and indefatigable worker in his county society, of which he had been president, and of his state society which he had served in various capacities, among them chairman of the Medical Section. He was an enthusiastic member of the American Medical Association and the American College of Physicians. He was a member of the staff of the Lutheran Hospital of Fort Wayne, the Board of the Irene Byron Sanatorium for Tuberculosis, and was a director and vice-president of the Anti-Tuberculosis League of Fort Wayne and Allen County.

Thoroughly scientific and open-minded in his professional work which he pursued with untiring zeal, Dr. Beall was equally generous and enthusiastic in civic affairs to which he gave freely of his time when called upon.

In the death of Dr. Beall his community and the state of Indiana have lost not only one of the ablest disciples of his profession but one of the most lovable citizens that Providence has ever placed in their midst. To his bereaved family and to his community which loved him so much, THE JOURNAL wishes to extend its profound sympathy and joins them in revering the memory of this one of "God's chosen few."

WILLIAM A. LINE, M.D., of Hillham, died January 16, aged 84 years.

WILLIAM H. BOBBITT, M.D., of Indianapolis, died February 8, aged 66 years. Dr. Bobbitt graduated from the College of Physicians and Surgeons, Baltimore, in 1882.

I. S. HAROLD, M.D., of Indianapolis, died February 6, aged 76 years, after an illness of more than a year. He graduated from the Physio-Medical College of Indiana, Indianapolis, in 1889.

EGBERT S. DICKERSON, M. D. (colored), of Indianapolis, died February 5, when his automobile was struck by a train. Dr. Dickerson was 54 years of age. He graduated from the Western Reserve University School of Medicine at Cleveland, Ohio, in 1898.

DR. FORREST J. YOUNG, M. D., of Milford, died February 8, aged 52 years. Death was caused from arterio-sclerosis. Dr. Young was a World War surgeon; was a member of the Kosciusko County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from the Indiana Medical College, School of Medicine of Purdue University, in 1907.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in The Journal of The Indiana State Medical Association. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

Dr. William D. Schwarts, of Portland, and Miss Goldie Lowman, of Anderson, were married January 31st.

The National Board of Medical Examiners has announced the removal of its office to Rooms 608-12, N.E. Corner Fifteenth and Locust Streets, Philadelphia.

Drs. Wishard, Hamer and Mertz, of Indianapolis, announce the removal of their office to 1711 North Capitol Avenue.

Dr. C. Norman Howard, of Warsaw, recently underwent an operation at the McDonald hospital and is improving rapidly.

The Madison County Medical Society had a party at the Grand Hotel, Anderson, February 21, in charge of the Ladies Auxiliary.

At the January 10th meeting of the State Board of Medical Registration and Examination, the license of Dr. Frederick J. Freshley, of Plainville, was restored.

John Woods Malmstone, four years old, only son of Dr. and Mrs. F. A. Malmstone of Griffith, Indiana, died January 8, following a two days' illness from pneumonia.

Dr. Albert E. Sterne, of Indianapolis, addressed the members of the St. Joseph County Medical Society February 15. His subject was "Some Factors in the Criminal Equation."

The Fort Wayne Medical Society held its regular meeting in the Wayne Pharmacal Building, February 21st. Dr. B. VanSweringen presented a paper on "Fistula Following Caesarean Section."

At a recent meeting of the Muncie Academy of Medicine, held at the Hotel Delaware, Dr. H. D. Fair, of Muncie, presented a paper on "Some Notes from the Race Betterment Conference at Battle Creek."

The Indiana University School of Medicine at Indianapolis was host to the members of the Indianapolis Medical School at the Medical School Building, January 31st. The school provided the program for the evening.

The Fountain-Warren County Medical Society held a meeting in Veedersburg, February 6, to which the public was invited. A large audience heard a good talk on the "Evolution of the Medical Practice Act," by Hon. Albert Stump.

The Indiana Roentgen Society was organized in Indianapolis, January 28th, with the following officers: President, Dr. R. C. Beeler, of Indianapolis; president-elect, Dr. H. J. Pierce, of Terre Haute; vice-president, Dr. L. F. Fisher, of South Bend; secretary-treasurer, Dr. C. S. Oakman, of Muncie.

The U. S. Civil Service Commission announces open competitive examinations for occupational therapy aide (arts and crafts); occupational therapy aide (trades and industries); occupational therapy aide (poultry raising); and occupational therapy aide (gardening). Full information may be obtained from the U. S. Civil Service Commission at Washington, D. C. Examinations will be rated as received until June 30.

Dr. D. L. Phipps, of Whiteland, was re-elected president and Dr. W. L. Portteus was re-elected secretary-treasurer of the Johnson County Medical Society for 1928 at the regular monthly meeting of that society held at Franklin, January 24th.

Dr. George F. Keiper, of Lafayette, is taking a two-year postgraduate course in ear, nose and throat work in Philadelphia.

Dr. Willis E. Gatch, Indianapolis, has been appointed head of the department of surgery (including gynecology and orthopedic surgery) of the Indiana University School of Medicine at Indianapolis, succeeding the late Dr. John H. Oliver. Dr. William H. Kennedy was appointed associate professor in medicine (radium therapy); Dr. Henry O. Mertz was promoted from assistant to associate professor in genito-urinary surgery.

The U. S. Civil Service Commission announces open competitive examinations for social worker (psychiatric) and Junior social worker. Examinations are to fill vacancies in the Veterans' Bureau and in positions requiring similar qualifications throughout the United States. Applications will be rated as received until June 30. Full information may be obtained from the United States Civil Service Commission at Washington, D. C.

The U. S. Civil Service Commission announces open competitive examinations for Assistant Medical Officer, Associate Medical Officer, Medical Officer and Senior Medical Officer. Applications will be rated as received by the Civil Service Commission at Washington, D. C., until June 29, 1928. There is especial need for medical officers qualified in tuberculosis or neuropsychiatry. Ap-

plication blanks (Form 2600 and 2398) and full information may be obtained from the U. S. Civil Service Commission at Washington, D. C.

THE Thirteenth Annual Convention of the Catholic Hospital Association of the United States and Canada and the second annual Hospital Clinical Congress of North America, will be held in the Cincinnati Music Hall, Cincinnati, Ohio, June 18th to 22nd, inclusive. The Fourth annual convention of the International Guild of Nurses will be held at the same time. Complete information concerning addresses and clinics may be obtained from John R. Hughes, M.D., Dean of the College of Hospital Administration, Marquette University, Milwaukee, Winsconsin, who is general chairman of the convention.

THE American Spring Assemblies of the Interstate Postgraduate Medical Association of North American will begin May 16th and last through June 10th, 1928. Visits will be made to the University and Hospital clinics of the southern and western part of the United States, closing at Rochester, Minnesota, in time to permit members of the assemblies to attend the meeting of the American Medical Association at Minneapolis, June 11th to 15th. Members of the medical profession who desire to accompany the spring assemblies should send their names at once to be registered. Complete information may be obtained by writing to Dr. William B. Peck, managing-director, Freeport, Illinois.

THE Huesmann Foundation of the James Whitcomb Riley Hospital for Children has announced, through the Indiana University School of Medicine, a research fellowship, open to medical graduates who have had at least two years internship in acceptable hospital, at least one of which must have been in the specialty in which research will be undertaken. In making selection consideration will be given to men who have shown research ability. Appointment will be for three years, at $2,500 per year, in any field relating to children's health. Applications will be accepted with records and references at any time up to May 15, the service to begin July 1, 1928. Applications should be sent to Dr. Burton D. Myers, Secretary of Committee, Indiana University School of Medicine, Indianapolis, Indiana.

THE Northern Tri-State Medical Association will hold its annual meeting in Detroit, Tuesday, April 2nd. The headquarters will be the Auditorium of the Detroit College of Medicine and Surgery. The program includes clinics and papers by the following: Drs. E. D. Spalding, Douglas Donald and Robert L. Novy, of Detroit; Dr. H. O. Mertz, of Indiana University School of Medicine; Dr. James E. Davis of the Detroit College of Medicine and Surgery; Drs. Howard P. Doub and Frank W. Hartman of the Ford Hospital, Detroit; Dr. John G. Fitzgerald, of the University of Toronto; Dr. Walter H. MacCracken, Detroit College of Medicine and Surgery; Dr. Cyrus T. Sturgis of the Simpson Memorial, Ann Arbor, Michigan; Drs. Andrew P. Biddle and Robert C. Jamieson, of the Detroit College of Medicine and Surgery; Drs. Fred A. Coller, and John Alexander, of the University of Michigan; and Dr. Elliot C. Cutler, professor of surgery of the Western Reserve University, Cleveland, Ohio. Officers of the Association in charge of the meeting are: Dr. Wm. M. Donald, Detroit, president; Dr. W. W. Beauchamp, Lima, Ohio, vice-president; Dr. R. V. Hoffman, South Bend, Indiana, treasurer; and Dr. Norris W. Gillette, Toledo, Ohio, secretary.

THE fourth award of the Leslie Dana Medal, presented annually through the Missouri Association for the Blind to the person selected from the nominations received by the National Society for the Prevention of Blindness, will take place during the 1928 meeting of the American Academy of Ophthalmology and Otolaryngology, in St. Louis, Missouri. Nominations will be received by the National Society for the Prevention of Blindness, together with detailed information prompting the nomination, until the fifteenth day of May, 1928. The medical profession is invited to submit names of persons deemed worthy of this honor to the National Society, under the conditions set forth in the deed of gift, as follows: 1. Long meritorious service to the conservation of vision in the prevention and cure of diseases dangerous to eyesight; 2. Research and instructions in ophthalmology and allied subjects; 3. Social service for the control of eye diseases; 4. Special discoveries in the domain of general science or medicine of exceptional importance in conservation of vision. The first medal was awarded in 1925 to Dr. Edward Jackson, of Denver; the second, in 1926, to the late Miss Louisa Lee Schuyler of New York City; and the third, 1927, to Dr. Lucien Howe, of Cambridge.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Hermes-Groves Dairy Co.:
Bacillus Acidophilus Milk-Hermes.

Lederle Antitoxin Laboratories:
Anterior Pituitary Desiccated-Lederle.
Posterior Pituitary Desiccated-Lederle.
Whole Pituitary Desiccated-Lederle.

Eli Lilly & Co.:
Iletin (Insulin-Lilly) U-100, 10 cc.
Liver Extract No. 343.

H. K. Mulford Co.:
Double End Vial.

Sterile Solution of Dextrose (d-Glucose) 50 cc. Double-End Vial.

Sharp & Dohme:

Hexylresorcinol Solution S. T. 37.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

January 23, 1928,

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., Chairman; Murray N. Hadley, M.D., by proxy; and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held January 16 read, corrected and approved.

The Bureau read and corrected a series of three releases upon periodic health examination and made plans for a fourth release upon periodic health examination and its connection with the early recognition of tuberculosis. Titles and release dates of these four articles follow:

January 28, Article I, "Periodic Health Examinations."

February 4, Article II, "Annual Health Audits."

February 11, Article III, "Why Periodic Health Examinations?"

February 18, Article IV, "Periodic Health Examinations as a Means of the Early Discovery of Tuberculosis."

This article is to be prepared and presented to the Bureau at its next meeting.

Special attention of the Editor of THE JOURNAL of the Indiana State Medical Association was to be called to this series of four articles, with a view to having this series published in THE JOURNAL. The Bureau thought that this should be done as these articles call the attention of the profession to the necessity of preparation to give periodic health examinations as well as calling the attention of the laity to the necessity of having periodic health examinations made.

The following letter was received from the secretary of the Minnesota State Medical Association:

> "We are contemplating offering a news service to the newspapers in Minnesota. Would you consider selling us your service? If so, how much and under what conditions could you send us some samples of material you are sending out? Thanking you very kindly, we are,
>
> Minnesota State Medical Association."

Instructions were given to send the secretary of the Minnesota State Society releases of Publicity articles and offer to help them establish a similar service in any way we are able, without charge.

A letter was received from the Indianapolis Community Fund concerning an advertisement appearing in an Indianapolis paper the afternoon of January 19 concerning a certain drug store. This was a drug store advertisement which said, "No worthy person need suffer a moment for want of proper medicine. Prescriptions will be filled free of charge at any ———— store upon presentation of a note from the doctor on his professional card stating the person is needy." The Community Fund in its letter says:

> "We would be interested in securing exact information about this new service furnished at———— and have you send us a report as to how the official agencies might make use of it for their needy clients."

Instructions were given to make an investigation and have such a report for the next meeting of the Bureau.

Report on meeting already held: Parent-Teachers Association, January 17, North Manchester: Subject "Preventive Medicine." Estimated attendance, 450.

Speaking engagements filled for meetings to be held:

January 24, Johnson County Medical Society. Subject, "Plaster of Paris and Some Factors on Fractures." Also a talk upon work being done by State Association.

January 25, Tri-County Medical Society meeting, North Vernon. Subject, "Upper Respiratory Influences."

January 27, Hendricks County Medical Society, Danville, Indiana. Subject, "Goitre."

February 6, Fountain-Warren County Medical Society, Veedersburg. Subject, "Medical Jurisprudence."

Speaking engagements to be filled: Jackson Township School, Rush County, Farmers Bureau meeting, 6:30 p. m., February 7. Request for speaker to talk on diphtheria and scarlet fever immunization and prevention, especially for the pre-school child.

From time to time "The Hoosier Health Herald," a publication of the Indiana Tuberculosis Association, carries publicity articles prepared by the Bureau. These were brought to the attention of the Bureau.

A letter was received from an Indianapolis newspaper in regard to comment made in THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION upon newspaper advertisments. The Bureau instructed the secretary to forward this letter to the editor of THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole January 30, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

January 30, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., Chairman; Murray N. Hadley, M.D., by proxy; and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held January 23 read, corrected and approved.

The Bureau read and corrected the second article on the Periodic Health Examination series. This article is to be released February 4. The Bureau also corrected Article III for release February 11.

An outline for the fourth article of the series which is to be upon the early diagnosis campaign of the National Tuberculosis Association was prepared and corrected by the Bureau. Two releases are to be prepared upon this subject.

Article IV for release February 18, "Periodic Health Examination as a Means for the Early Discovery of Tuberculosis."

a. Introduction.
b. Early Tuberculosis Campaign.
c. Publicity Plans.

Article V for release February 25, "Preparation of the Medical Profession to Give These Examinations." The Bureau reviewed pamphlets published by the National Tuberculosis Association for the Indiana Tuberculosis Association to distribute to the laity and physicians of the state.

Request from secretary of the Indiana Tuberculosis Association that a leaflet prepared by the director of the National Tuberculosis Association entitled, "The Early Diagnosis of Tuberculosis" be placed in each copy of the February issue of THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION. Request approved by Publicity Bureau. Secretary was instructed to bring this request before the editor of THE JOURNAL.

The Bureau also directed the secretary to write to the president of the Indiana State Medical Association asking him to appoint a physician to attend the annual meeting of the Indiana State Tuberculosis Association at Gary, February 15 and 16. This physician is to act as a representative of the Indiana State Medical Association

and make a report of the meeting for THE JOURNAL.

Letter upon "Annual Health Audit" was received from the Gorgas Memorial. Secretary was instructed to forward this letter to the editor of THE JOURNAL of the Indiana State Medical Association.

Medical items appearing in THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION under the Indiana heading were reviewed by the Bureau.

Bureau reviewed correspondence with the American Association for Medical Progress with a view to forming as Indiana Association of this organization.

Reports were received upon the following medical meetings:

January 17, Parent-Teachers Association, North Manchester.

January 24, Johnson County Medical Society, Franklin.

January 25, Tri-County Medical meeting, North Vernon.

January 27, Hendricks County Medical Society, Danville.

Requests for speakers:

February 7, Kiwanis Club, Cambridge, 6:15 p. m. Request for a talk upon "How Bacteria Produce Disease."

Suggestion was made that the Bureau prepare an article upon Hygiene for the fourth release.

Suggestion was also made that all letters going from office of executive secretary be stamped with the date of the annual convention.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole February 6, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

February 6, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., Chairman; Murray N. Hadley, M.D.; J. A. MacDonald, M.D.; and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held January 30 read, corrected and approved.

The Bureau read and corrected the third article on the periodic health examination series to be released February 11, and also reviewed the fourth article of the series which is upon the "early diagnosis campaign" of the National Tuberculosis Association to start in March. This article is to be released Saturday, February 18.

The Bureau received a report that the pamphlets on early diagnosis of tuberculosis prepared by the National Tuberculosis Association is to be placed in each copy of the February issue of THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION.

Reports were received upon the following meetings where speakers were supplied by the Bureau of Publicity:

January 25, Tri-County Medical Society meeting, North Vernon. Subject, "Upper Respiratory Infections."

The following meetings are to be held:

February 6, Fountain-Warren County Medical Society, Veedersburg. Subject, "Medical Jurisprudence."

February 7, Parent-Teachers Association, Jackson Township, Rush County School. Subject, "Diphtheria and Typhoid Prevention for Children."

February 7, Kiwanis Club, Cambridge. Subject, "How Bacteria Produce Disease."

Request for speaker:

February 27, Jefferson County Medical Society, Madison. Subject desired, "Periodic Health Examination."

Committee reviewed correspondence upon the appointment of a representative from the Indiana State Medical Association to attend the Indiana Tuberculosis Association meeting at Gary, February 15 and 16.

The following letter was received from John M. Dodson, M.D., executive secretary of the Bureau of Health and Public Instruction of the American Medical Association:

"Gentlemen—Will you kindly send us your series of four bulletins dealing with the definition, history, object, necessity, methods, difficulties, results and the growing success of the movement—periodic health examinations.

Yours very sincerely."

Secretary was instructed to send articles to Dr. Dodson.

Letter was also received from Mrs. Edna Hatfield Edmondson, executive secretary, Parent-Teachers Association, saying that she would be very glad to send the periodic health examination bulletins to the various parent-teachers organizations.

The following letter was received from Harry S. New, Postmaster General:

"Gentlemen:—I wish to thank you for your kind letter of the 25th inst., in which you express the appreciation of the medical profession of Indiana for the work done by this Department in ridding the mails of quack remedies and medical frauds.

"I am directing that the activities of W. J. Mesnard and C. Settles of Sullivan, Indiana, in selling an eczema cure through the mails, be made the subject of an investigation by post office inspectors.

Sincerely yours."

The Bureau of Publicity authorized the executive secretary to purchase a rubber stamp giving the time and place of the next annual convention. Each letter and envelope which goes from this office is to be stamped "1928 Annual Session—Gary, Lake County, September 26, 27 and 28."

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole, February 13, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

February 13, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., Chairman; J. A. MacDonald, M.D.; and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held February 6 read, corrected and approved.

The following bills were approved for payment:

The Bailey Office Supply, paper	$17.20
Central Press Clipping Service	5.00
American Medical Association	6.00
Total	$28.20

The Bureau read and corrected the fourth article of the Periodic Health Examination series to be released February 18. This article deals especially with the "early diagnosis campaign" of the National Tuberculosis Association which starts in March.

The following letter was received from the executive secretary of the Bureau of Health and Public Instruction of the American Medical Association:

"Dear Sirs:

Thank you very much for sending me copies of the articles on periodic health examinations which have been sent out from your office. I am very glad indeed to have these admirable articles for our files.

Yours very sincerely."

These articles had been formerly sent to the Bureau of Health and Public Instruction upon a request from that source.

The following letter was received from the secretary of the Minnesota State Medical Association:

"Gentlemen:

Thank you very much for your invitation, and I certainly will take the opportunity to visit one of your Publicity Bureau meetings.

"We thank you for the articles you sent us although we have not had time to go over them carefully yet.

"Thanking you again for your co-operation, I am,"

A letter was received from the secretary of the Indiana State Board of Health in answer to a letter from the Publicity Bureau, February 7, asking for information in regard to a public health meeting at Richmond, Indiana, where Koch cancer "cure" propaganda is alleged to have been circulated.

The following reports upon medical meetings were received:

February 6, Fountain-Warren County Medical Society, Veedersburg.

February 7, Parent-Teachers Association, Jackson Township, Rush County School. Meeting postponed on account of death of one of the sponsors.

February 15, Parent-Teachers Association, Center Township, Rush County. "Diphtheria and Scarlet Fever Prevention for Children."

February 16, Cass County Medical Society, Logansport. "Heart."

Meetings to be held:

February 27, Jefferson County Medical Society, Madison. Periodic Health Examination demonstration.

A delegate was appointed to represent the Indiana State Medical Association at the Indiana Tuberculosis Association annual meeting, at Gary, February 15 and 16.

Indiana notes in medical News Column of the American Medical Association Journal were reviewed.

There being no further business, the meeting was adjourned.

The foregoing minutes were approved in each separate part and as a whole February 20, 1928.

Wm. N. Wishard, M.D.,
Chairman.
Thomas A. Hendricks,
Secretary.

CARROLL COUNTY MEDICAL SOCIETY

January 31, 1928.

The Carroll County Medical Society met in monthly meeting at Flora, Indiana, with a splendid attendance.

Dr. Glen Pell, of Indianapolis, gave a very practical address on the subject of "Closer Co-operation Between Doctors and Dentists."

After the address the officers for the year of 1928 were elected and are as follows:

Dr. T. H. Peters, Flora, president; Dr. E. H. Brubaker, Flora, secretary-treasurer.

Our society meets the second Wednesday evening of each month excepting January, February and March.

E. H. Brubaker,
Secretary.

TIPPECANOE COUNTY MEDICAL SOCIETY

The Tippecanoe County Medical Society met in regular session at "The Windsor," West Lafayette, Indiana, February 9, 1928. Dinner was served at 6:15 p. m. with thirty-six members at nine tables. Nine nurses from the Home hospital were present for the scientific program. Every one present was more than pleased with the location, food and service provided.

President H. J. Laws presided. The minutes of the January meeting were read and approved. Motion was made and carried that Dr. Hupe send Dr. R. G. Ikins a bouquet of roses. A communication from Dr. A. C. Arnett was read, urging candidacy of Mr. H. G. Leslie for the republican nomination for governor of Indiana and that we earnestly recommend Mr. Leslie to all other county societies of the state for their most careful consideration. Motion was made by J. C. Burkle, seconded by F. S. Crockett, that this communication be accepted and placed on record, and that such recommendations be sent to all component county Medical Societies. The following resolution was drawn up:

"Whereas, Mr. Harry Leslie, a native and citizen of Tippecanoe County, has announced his candidacy for the Republican nomination for Governor of this state; and,

Whereas, Mr. Leslie is a man of sterling character, stalwart, honesty, and unquestioned integrity of purposes; and,

Whereas, Mr. Leslie, during the 1925 session of the legislature as floor leader, and during the 1927 session of the legislature as speaker of the House, was a bulwark of strength in upholding the principles of progressive, scientific medicine and medical education, unwavering in his determination toward those ends,

Therefore, be it resolved that the members of the Tippecanoe County Medical Society, in this manner, approve the candidacy of Mr. Leslie for the office which he seeks, and earnestly recommend Mr. Leslie for the sober consideration of the members of every county medical society through the state of Indiana."

Dr. Crockett reported the county commissioners considering a tuberculosis sanitarium and suggesting that the school site at Ouiatenon might be satisfactory for such sanitarium. Motion was made and seconded that the society endorse such move and assist in every way possible to carry it forth to a success. Discussion was given by Drs. Romberger, Shafer, Pyke, Kern, Bauer and Davisson. The vote was unanimous for the motion.

Motion was made and carried that a committee be appointed to investigate the above proposition and report back at the March meeting. Committee: Drs. C. V. Davisson, F. S. Crockett and F. L. Pyke.

Bills: Postmaster, for 500 stamped envelopes—$10.96. Sixty-seven members have paid 1928 dues.

A list of the members of committees for the district meeting to be held on May 17, 1928, was read by the secretary.

Dr. Laws presented the paper of the evening, entitled "Synergistic Analgesia in Labor." He gave a very fine presentation of the mixture, method of procedure, results, and some concise statistics to show the value of such method.

Respectfully,
J. C. Burkle, M.D.,
Secretary.

VANDERBURGH COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Vanderburgh County Medical Society was held at St. Mary's hospital, of this city, Tuesday evening, February 14, at 8:15 p. m.

Dr. John W. Visher was accepted into the society by transfer from the Waukesha County Medical Society of Wisconsin.

The program was conducted by the members of the staff of St. Mary's hospital. The following interesting clinical cases were presented:

Dr. H. L. Stanton—Interstitial Keratitis.

Dr. W. E. McCool—An Unusual Pelvic Hernia

Dr. G. C. Johnson—Cancer of the Lung.

Dr. G. B. Underwood—Ringworm of the Scalp.

Dr. B. H. Beeler—Surgical Removal of a Foreign Body in the Rectum.

Dr. W. S. Erich—Surgical Removal of an Exceedingly Large Tumor of the Prostrate.

Dr. W. W. Hewins—Pyelonephritis.

The surgical procedures, used in the treatment of some of these cases, were illustrated by moving pictures.

The total number of physicians in attendance was

fifty-six. A large number of the graduate nurses of Vanderburgh county were also in attendance. The staff of St. Mary's hospital is to be congratulated on the excellent program.

The secretary of the society is considerably elated over the fact that of a total membership of ninety-four for the year 1927, ninety-two of the members have already paid their dues for 1928. Notices were sent to the various members, who had not paid by January 1, 1928, notifying them that the dues for the current year were now payable. Not one of the physicians, who received a notice of this kind, took exception to it; in fact, nearly every member approached in this manner, apologized for not having paid his dues on the first of January.

The program committee for the past two years has arranged to have a "Clinic Program" for the monthly meetings. These clinics have been held at the various hospitals in the city and in the county. During the year 1927, "Clinical Programs" were held at The Walker Hospital clinic, St. Mary's hospital, Deaconess hospital, Boehne Tuberculosis hospital, Southern Indiana Hospital for Insane, Vanderburgh County Venereal and Skin Clinic, and a Pediatrics clinic was held at the Evansville Public Health center.

KEITH T. MEYER, M.D.,
Secretary.

VIGO COUNTY MEDICAL SOCIETY WOMAN'S AUXILIARY

With the assistance of the state president, Mrs. Cregor, the Woman's Auxiliary to the Vigo County Medical Society was organized November 22, 1927. Since then monthly meetings have been held.

In February the hospitality committee and the executive board acted as hostesses for a tea, given in the community cabin of Edgewood Grove. A dinner is planned for the March meeting, at which Mr. Thomas Hendricks, executive secretary of the Indiana State Medical Association, will be the speaker.

This auxiliary has forty-nine members. The following officers are serving for 1928: President, Mrs. O. O. Alexander; vice-president, Mrs. T. T. Moorhead, Mrs. D. R. Ulmer and Mrs. W. E. Stewart; recording secretary, Mrs. W. D. Asbury; treasurer, Mrs. C. N. Combs.

Respectfully,
MRS. D. B. MILLER,
Corresponding Secretary.
Woman's Auxiliary, Vigo County Medical Society.

MADISON COUNTY MEDICAL SOCIETY

The Madison County Medical Society held its regular February meeting at the Grand Hotel, Tuesday evening, February 21, and as planned at the last meeting its success was assured, because its sponsors were the Ladies Auxiliary. Mrs. M. A. Austin had appointed Mrs. H. W. Gante, Mrs. Erehart, Mrs. Wilder, Mrs. Hunt of Pendleton, and Mrs. Walton to put the affair over in proper style and manner and that it was a grand success every one admitted. Some sixty physicians and their wives, a half dozen nurses, and several members of the physicians' families sat down to a banquet and listened to some excellent talks by Mrs. John Armington, who spoke on the ever popular subject, "What it Means to be a Doctor's Wife," and Dr. Stottlemeyer, who spoke on the subject of "What it Means to Belong to the Ladies Aid." Mrs. Armington said this was the first time since she was married that she had a real chance to say what she had long desired to do, and she hoped the crowd would prevent her husband from interrupting her until she had finished all she wanted to say. Dr. Stottlemeyer spoke of some of his experiences and amused the audience greatly. Mrs. Austin, president of the Madison County Ladies Auxiliary, presided as toastmaster. After the dinner hour, Miss Martha McDougal, a graduate nurse, and head of the surgery at the Methodist hospital in Indianapolis, and who is an accomplished musician and vice-president of the Mendelsohn Choir in Indianapolis, was introduced and in Scotch costume gave three groups of Scotch songs, to the great pleasure of all those present. Between Miss McDougal's song groups, five girls of this city, pupils of Miss Canavan, and headed by Mary Walton, daughter of Dr. Walton, gave two ballet numbers of excellent dancing. At 9 o'clock Joe Faulkner's orchestra appeared and gave two hours of dance music which entertained some forty persons while five tables of bridge was enjoyed by the rest of the crowd.

Those in attendance were Drs. and Mrs. Armington, Austin, Brauchla Collins, Conrad, Erehardt, Guthrie, E. F. King, Kopp, Long, Stottlemeyer, Walton, Wilder, Wishard, Dr. Quickel, Misses Freese, Williams, Conger, Lentz, and Lyons of Anderson, Dr. Hunt and wife and Dr. Sparks of Pendleton, Dr. and Mrs. Merle Hoppenwrath and Dr. and Mrs. Lauderman of Elwood, Dr. and Mrs. Hall and Dr. Schurtz of Alexandria, Dr. and Mrs. Mobley of Summitville, Miss McDougal and Miss Lucas of Indianapolis, besides a number of the younger members and friends of the physicians' families.

This was an ACQUAINTANCE PARTY and the first of three social affairs planned by the Woman's Auxiliary for this year. In April the wives will come to the dinner with their husbands and during the program of the medical society after the dinner, the ladies will be entertained by Mrs. Gante. In June there will be a picnic, medical program and outing, and an invitation has been accepted from Dr. Merle Hoppenwrath to hold it at their country home, opposite the country club south of Elwood.

Dr. Charles F. Neu of Indianapolis will be the guest speaker at the next meeting which will be held on Tuesday evening, March 20.

M. A. AUSTIN, M.D., Secretary.

CORRESPONDENCE

RAILROAD ACCOMMODATIONS TO THE MINNEAPOLIS SESSION OF THE AMERICAN MEDICAL ASSOCIATION.

To the members of the American Medical Association:

The American Medical Association will hold its next meeting in Minneapolis, June 11-15, 1928, and I wish to call your attention to the service offered by the Chicago Great Western, Chicago to Minneapolis.

In order to make the trip a success, we are writing each of the secretaries of your organization throughout the eastern states, asking them to inform the members of each individual society to join the special train party from Chicago and go up in these special Pullman trains to the Minneapolis convention. By doing so, we have in mind not only their travel comforts, but the opportunity it will afford them to meet their friends and spend an enjoyable social evening on the train leaving Chicago.

The Chicago Great Western is the only line operating service between Chicago and the Twin Cities via Rochester, Minn. Our station is located one and one-half squares from the leading hotels and the clinic at Rochester, Minn. Stop-over at Rochester is permitted on either going or return trip or both.

Those desiring reservations on the regular train can leave Chicago daily at 6:30 p. m. on our splendid train "The Legionnaire" leaving Chicago 6:30 p. m., arriving St. Paul 7:10 a. m., Minneapolis 7:50 a. m. This splendid over-night train leaves from the Grand Central station, Harrison and Wells Sts., Chicago. There will be extra Pullmans on this train for the accommodation of members of your society on June 9th and 10th. Returning, these special trains will leave Minneapolis after the adjournment of the meeting, and will arrive at Chicago in ample time to make eastern and southern connections.

The regular one-way fare from Chicago to Minneapolis is $14.66; lower berth, $3.75; upper, $3.00; drawing room, $13.50; compartment, $10.50. Members of your society can purchase through tickets to Minneapolis

from their home town, requesting that tickets be routed via C. G. W. R. R. to insure their traveling with the special party, and which will also effect a great saving, because if they decide to return or go via Rochester, as stated above, there will be no additional charge made when tickets are routed over the Chicago Great Western.

Will you kindly inform members of your society as to these arrangements. Sleepers will be parked at Minneapolis. Further information regarding the parking of these cars will be given you at a later date.

The fare, in most cases, to this convention will be at the regular convention fare, or fare and one-half for the round trip.

Yours truly,

THOMAS G. KEES,
District Passenger Agent.
Chicago Great Western R. R. Co., Chicago, Ill.

Indianapolis, January 30.

To the members of the American Medical Association:

We understand that the next convention of your organization will be on June 11th-15th, 1928, at Minneapolis, and we wish to offer you the services of the Chicago, Milwaukee, St. Paul and Pacific R. R. C., for your trip.

Our operation to the Twin Cities consists of fourteen trains daily, featuring the "Pioneer Limited" which leaves the new Chicago Union Station at 6:30 p. m., arriving at Minneapolis at 7:55 a. m., also the most famous of all trans-continental trains, the "Olympian" which leaves at 11:00 p. m. arriving at 11:50 a. m. The remaining trains depart at all convenient hours and from this consist you may have your choice. It is our desire to offer your party special service from Indianapolis to Minneapolis, via any of the local lines from Indianapolis, providing sufficient inquiries are so received.

Our line is double tracked for the entire distance, which will prevent unnecessary delays usually encountered otherwise. We were the "Pioneer" line between Chicago and the Twin Cities, first and only road operating over its entire rails from Chicago to the North Pacific coast, first to adopt roller-bearings, first to operate all steel trains between these points, the longest electrified railroad in the world, operating for 660 miles through four mountain ranges and the first to direct its operation by radio.

Our passenger experts are ready to serve you with information regarding your summer tourist fares, post convention trips and any other information that you may desire.

We trust that you will give our line due consideration in the selection of your route.

Yours very truly,

A. K. POWERS,
City Freight and Passenger Agent,
Chicago, Milwaukee & St. Paul R. R.,
Indianapolis, Ind.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

The following books have been received since January 1, 1928.

EXTRA-OCULAR MUSCLES. By Luther C. Peter, M.D., Sc.D. Cloth. Price $4.00. 294 pages. Illustrated. Lea and Febiger, Philadelphia. 1927.

PRACTICAL THERAPEUTICS. By Hobart A. Hare, M.B. Sc., M.D., LL. D. Cloth. Price $7.50. 1094 pages, with 166 illustrations. Twentieth edition, enlarged, thoroughly revised. Publishers, Lea and Febiger, Philadelphia, 1927.

APPENDICITIS. By H. A. Royster, A.B., M.D. Cloth. Price $7.00. Illustrated. D. Appleton and Company. New York and London, 1927.

BABY'S HEALTH FROM DAY TO DAY. A daily record book. From The Professional Press, Inc., Chicago.

PHYSICAL DIAGNOSIS. By Charles P. Emerson, A.B., M.D., dean of the Indiana University School of Medicine. Cloth. Price $7.00. 553 pages with illustrations. J. B. Lippincott Company, Philadelphia, 1928.

BEDSIDE DIAGNOSIS. By George Blumer, M.D. Cloth. Price $30.00 for set of three octavo volumes. Index volume free. 2820 pages. 890 illustrations. W. B. Saunders Company, Philadelphia, 1928.

PATHOLOGICAL PHYSIOLOGY OF INTERNAL DISEASES. By A. W. Hewlett. M.D. Cloth. Price $8.50. Illustrated. D. Appleton and Company, New York and London, 1928.

GYNECOLOGY. By Howard A. Kelly, M.D. Cloth Price $12.00. Illustrated. D. Appleton and Company, New York and London, 1928.

MODERN BAKING POWDER. By Juanita E. Darrah. Cloth. Price $1.00. Commonwealth Press, Chicago, 1928.

SURGICAL CLINICS OF NORTH AMERICA. Volume 7, No. 5 (October, 1927). 266 pages with 132 illustrations. Price, per clinic year, February, 1927 to December, 1927), paper $12.00, cloth $16.00. Issued every other month. W. B. Saunders Company, Philadelphia and London.

INTERNATIONAL CLINICS. Volume IV. Thirty-seventh series. 1927. J. B. Lippincott Company, Philadelphia and London, 1927.

OPHTHALMIC OPTICS. By Alfred Cowan, M.D., assistant professor of Ophthalmology in the Graduate School of Medicine, University of Pennsylvania. 121 illustrations, some in colors. F. A. Davis Company, Philadelphia. 1927. Cloth. Price, $3.50.

The purpose of this book is to convey a working knowledge of ophthalmic optics to students and practioners, and it does so through a system of instruction which is not only scientifically correct but is consistent with thoroughness. The chapters on lenses and their uses and applicability to optical defects are instructive, and the chapter on ophthalmoscopy and retinoscopy is a concise presentation of the subject. This book ought to be of great interest to all students of ophthalmic optics.

OPHTHALMOSCOPY, RETINOSCOPY AND REFRACTION. By W. A. Fisher, M.D., F.A.C.S., Professor of Ophthalmology, Chicago Eye, Ear, Nose and Throat College, etc. Second revised and enlarged edition. 260 illustrations including 48 colored plates. F. A. Davis Company, Philadelphia. 1927. Cloth. Price, $3.75.

This is an excellent textbook for the beginner, but we cannot agree with the author that ophthalmoscopy and the fitting of glasses belongs to the general practitioner, and that an acquirement of the necessary practical and theoretical knowledge is easy, interesting and within the reach of all. The author seems to think that possession of his little textbook is all that is necessary in order to enable the general practitioner to master the methods necessary for one who is to become proficient in the use of the retinoscope and the ophthalmoscope. As a rule the ophthalmoscope gets the general practitioner into more trouble than it gets him out of, and we have seen this illustrated many times in instances where very competent general practitioners have had more than ordinary instructions in the use of the ophthalmoscope in their practices. However, Dr. Fischer's book is excellent, though we would consider it applicable to the beginner in ophthalmology rather than the general practitioner who expects to play with the retinoscope or the ophthalmoscope, even though he does not prove by his practice the old saying, "A little knowledge is a danger-

ous thing." The book is splendid illustrated with 212 halftones and 48 colored plates. It is made still more valuable through new chapters on the red free light, the Gullstrand binocular ophthalmoscope, and microscopy of the living eye by slit lamp illumination.

THE NEW MEDICAL FOLLIES. By Morris Fishbein, M.D., editor of the Journal of the American Medical Association and of Hygeia, the Health Magazine. Boni and Liveright, 1927. New York. Price, $2.00.

Anyone who read the original Medical Follies by Dr. Fishbein may know what to expect in The New Medical Follies published recently. The book includes, as the title page says, a discussion of cultism and quackery, together with essays on the Cult of Beauty, the Craze for Reduction, Rejuvenation, Bread and Dietary Fads, Physical Therapy, and all those who are swindling the public through the borderline of medical practice. Dr. Fishbein attacks boldly and with an argument that is convincing as well as entertaining. This book, like its predecessor, should be on the table in the reception room of every physician so that people may have the opportunity of learning something about fads and quackery in general.

DISEASES OF THE MOUTH. By Sterling V. Mead D.D.S., Professor of Oral Surgery and Diseases of the Mouth, Georgetown Dental School: Oral Surgeon to Georgetown Hospital: Dental Surgeon to Providence Hospital, etc., Washington, D.C. 578 pages with 274 original illustrations in the text and 29 full page color plates. St. Louis, The C. V. Mosby Company, 1927, price $10.00.

The fact that dentistry is rapidly becoming a real specialty of medicine and that the dental and medical profession are developing a more intimate co-operation in the effective handling of diseases of the mouth and their effect on the general health can be no better illustrated than by referring both physician and dentist to this book. Something new of its kind, it should be in the library of every member of both professions for although written primarily as a text book for dental and medical students it contains a world of scientific medicine as it relates to the mouth. The book is profusely illustrated with radiograms, photographs (many beautifully colored) and with micro-photographs of diseased tissues and pathogenic bacteria. The chapter on radiograms of the teeth is especially fine, showing the normal structures, explaining the damages of misinterpretation and taking up x-ray burns. There is a chapter on pulp testing and one on transillumination of the sinuses. Dentists are more and more making use of the clinical laboratory and in this work the bacteriology and pathology of the mouth is done thoroughly and well. The microphotographs of tumors of the mouth are particularly good. All the known diseases of the mouth, gums and teeth are given a thorough treatment as to diagnosis, etiology, pathology, their relation to the general health and their treatment.

MEDICAL SCIENCE FOR EVERYDAY USE, by Shields Warren, A.B., M.D. Instructor in Pathology in the Harvard Medical School; Pathologist Palmer Memorial Hospital, Boston, Massachusetts. 160 pages. Lea & Febiger, Philadelphia, Price $2.00.

This work is a reprint of a series of articles of current medical interest to the laity which appeared in the Boston Sunday Herald. It takes up the growth of children, work, exercise, diet, school children, sleep, germs, blood poisoning, the common diseases, food poisoning, autointoxication and appendicitis. This little book might be in every home.

THE PRINCIPLES OF SANITATION. A practical handbook for public health workers, by C. H. Kibbey, Director of Sanitation, Tennessee Coal, Iron and Railroad Co., Birmingham, Ala. With 34 illustrations, including 5 color plates. Price $3.50. F. A. Davis Co., Publishers, Philadelphia, 1927.

This is a new and wonderful book comprising the material used in a series of lectures calculated to instruct Sanitary Inspectors. It should be a valuable reference to any one interested in sanitation.

PROCEEDINGS OF THE NINETEENTH AND TWENTIETH CONFERENCES OF AMERICAN ASSOCIATION OF MEDICAL MILK COMMISSIONS. In conjunction with The Certified Milk Producer's Association of America. Nineteenth Annual Conference held at Atlantic City, N. J., May 25 and 26, 1925. Twentieth Annual Conference held at Dallas, Texas, April 19 and 20, 1926. Brooklyn, N. Y., 1926.

This book gives the complete proceedings including addresses and discussions.

BACTERIA IN RELATION TO MAN. A study-text in general microbiology by Jean Broadhurst, Ph.D. Associated professor of biology, Teachers College, Columbia University. 306 pages, 147 illustrations. Philadelphia and London, J. B. Lippincott Co., Price $3.00.

This book is designed as an introduction to Microbiology and includes both text and practical laboratory material. Beginning with the life history of the cell, the life and nature of micro-organisms and their relations to disease is gradually unfolded.

MINERAL WATERS OF THE UNITED STATES AND AMERICAN SPAS by William Edward Fitch, M.D. 800 pages, illustrated. Price $8.50. Lea and Febiger, Philadelphia and New York, 1927.

This is probably the most comprehensive work on mineral waters of the U. S. yet written. The first chapters deal with the classification and uses of mineral waters in disease and should create a more thorough understanding of the subject of medical hydrology. Several chapters are devoted to the ingredients of mineral waters and their physiological action, including radio-activity, with indications for their use. Then the mineral waters in each state of the union is fully described. It should be a valuable addition to the medical library.

ABSTRACTS

POSTNATAL MATERNAL CARE

Maud Parker, Seattle (*Journal A. M. A.*, Dec. 17, 1927), insists that postnatal maternal care should extend over a period of one year. Maternal care from the first to the twelfth day of the puerperium must include control of hemorrhage, repair of all subcervical lacerations, prevention of dilatation of the pelvic viscera, the promotion of drainage, and the restoration of pelvic circulation, together with the establishment of lactation. During the following four weeks of puerperal life, the mother should be so controlled as to rest, exercise and nutrition as to re-establish her former habits of living, with only such restrictions as seem necessary to insure complete involution of the genitalia. The parturient should not be discharged from observation for one year after confinement, and during this period should receive monthly examinations of the breast, abdominal muscles, genito-urinary tract, ductless glands and nervous system, and be given such treatment as is indicated for correction of the late appearing pathologic changes of these organs.

COMPOSITION OF PROCAINE BORATE (BOROCAINE)

George W. Collins, Chicago (*Journal A. M. A.*, Jan. 7, 1928), analyzed this product in the chemical laboratory of the American Medical Association. He says: The product marketed as "Borocaine" is procaine borate, a borate of *p*-aminobenzoyl-diethylaminoethanol. It is a

definite chemical compound. It is readily hydrolyzed when dissolved in water, and acts as an aqueous solution of boric acid to which has been added procaine (base). The formula $C_{13}H_{20}O_2N_2.4B(OH)_3$, as first ascribed by Einhorn and Uhlfelder, also the formula $2(C_{13}H_{20}O_2N_2).4H_2O, 5B_2O_3$, reported by Copeland and Notton, were not verified. It is concluded from the analytic data obtained that Borocaine possesses the formula $C_{13}H_{20}O_2N_2.5HBO_2$, and that it is not a hitherto undiscovered compound. Except as noted, the product conforms to tests of identity and purity for procaine borate of the formula $C_{13}H_{20}O_2N_2.5HBO_2$.

SUGGESTED TEST FOR PREGNANCY

The technic of the test suggested by A. C. Siddall, Cleveland (*Journal A. M. A.*, Feb. 4, 1928), is as follows: Twenty-five cubic centimeters of patient's blood is collected in a sterile tube and permitted to clot. The serum is withdrawn into another sterile tube and kept in the refrigerator. One cubic centimeter of the blood serum is injected subcutaneously into an immature virgin white mouse once daily for four or five days. On the sixth day, a vaginal smear is made according to the method elaborated by Allen and Doisy in order to determine the phase of the estrual cycle of the mouse. The animal is then killed, and the weight in milligrams is immediately determined on a chemical balance. The bicornate uterus together with the ovaries is dissected out in one piece free from the vagina and other attachments and the weight in milligrams determined on a chemical balance. The weight of the mouse is divided by the weight of the uterus plus the ovaries, and the resulting ratio is the criterion for a positive or negative conclusion. The results to date indicate that a ratio below 400 is positive for pregnancy while a ratio above 400 is negative for pregnancy. Forty-five patients in all were tested. Of nineteen non-pregnant patients, eighteen gave a negative mouse test. Of twenty-six pregnant patients, twenty-five gave a positive mouse test.

CHRONIC LEAD POISONING FROM SNUFF

Of three cases of chronic lead poisoning from the habitual use of snuff containing lead, reported by Joseph Uttal, New York (*Journal A.M.A.*, Jan. 28, 1928), two resulted in marked polyneuritis with bilateral wrist drop and extensive muscular atrophy; one resulted in marked secondary anemia. All three cases were chemically proved by the identification of lead from snuff used by the three patients. Lead was also found in significant quantities in the excreta of two of the three patients. The continued sale of this snuff constitutes a menace to public health. Snuff tobacco may contain lead from two sources: 1. Snuff wrapped in tin-foil containing a large portion of lead in its composition may cause lead poisoning if the contents become moistened by causing minute amounts of lead to pass into solution and become incorporated in the snuff. The continual inhalation of lead in small amounts will lead to chronic poisoning because of the cumulative nature of the poison and also because the respiratory tract is the most rapid source of the dissemination of lead, since it leads directly to the general circulation and avoids the detoxifying action of the liver. Such a case causing fatal poisoning was reported by Stadler. A certain specimen of snuff used by a woman was wrapped in metal foil containing eighty-nine per cent lead, although the Swiss code of 1909 forbids the use of such foil when it contains more than one per cent of lead. The snuff when examined was moist and contained from 1.75 to 1.90 per cent of lead. This caused a fatal intoxication by habitual use. Zangger states that the daily dose of from 8 to 10 mg. of lead causes chronic poisoning. 2. Lead may be an actual adulterant of snuff tobacco. It is used in the process of the manufacture of snuff as a coloring agent in the form of lead chromate. In the cases reported, the snuff suspected and proved to contain lead was the most inexpensive of the available brands. This particular brand of snuff was the product of one manufacturer.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Bacillus Acidophilus Milk-Hermes.—A whole milk cultured with *B. acidophilus*. It contains not less than 200 million of viable organisms (*B. acidophilus*) per cc. at the time of sale. For a discussion of the actions, uses and dosage of bacillus acidophilus preparations, see New and Nonofficial Remedies, 1927, p. 216, "Lactic Acid-Producing Organisms and Preparations." Hermes-Groves Dairy Co., Pittsburgh. (*Jour. A. M. A.*, January 14, 1928, p. 117).

Phanodorn. — Cyclobarbital. — Phanodorn differs from barbital (diethyl-barbituric acid) in that one of the ethyl groups of barbital is replaced by a cyclohexenyl group. The actions and uses of phanodorn resemble those of barbital, but it is more than twice as active as barbital and the therapeutic dose is correspondingly smaller. It is eliminated more rapidly than barbital; hence the action is not so lasting. This is an advantage when it is used merely to put one to sleep where sleep will then continue without its further action. It is used mainly for its sedative action. Winthrop Chemical Co., Inc., New York. (*Jour. A. M. A.*, January 14, 1928, p. 117).

Sterile Solution of Dextrose (d-Glucose) 50 cc. Double End Vial.—Each vial contains Dextrose, U.S.P., 25 Gm.; cresol, 0.1 per cent; distilled water, to make 50 cc.; buffered with diabasic sodium phosphate anhydrous and potassium biphosphate anhydrous. H. K. Mulford Co., Philadelphia.

Hexylresorcinol Solution S. T. 37.—A solution of hexylresorcinol-S. & D. (New and Nonofficial Remedies, 1927, p. 320), 1 part, in a liquid composed of glycerin 30 per cent and water 70 per cent, 1,000 parts. Sharp & Dohme, Baltimore.

Iletin (Insulin-Lilly) U-100, 10 cc.—Each cubic centimeter contains 100 units of insulin-Lilly (New and Nonofficial Remedies, 1927, p. 198). Eli Lilly & Co., Indianapolis. (*Jour. A. M. A.*, January 28, 1928, p. 293).

PROPAGANDA FOR REFORM

The Composition of Procaine Borate (Borocaine).—At the request of the Council on Pharmacy and Chemistry the American Medical Association Chemical Laboratory made an investigation of "Borocaine," marketed by Sharp & Dohme, particularly with a view of determining whether it presented sufficient novelty to permit recognition of the proprietary name. The study was made by George W. Collins, Sc. D., who concludes that the product marketed as "Borocaine" is procaine borate; that it is a definite chemical compound which is readily hydrolyzed when dissolved in water, and acts as an aqueous solution of boric acid to which has been added procaine (base). He concludes that it is not a hitherto undiscovered compound. (*Jour. A. M. A.*, January 7, 1928, p. 25).

Nobro.—This is another phenobarbital (luminal) mixture sold as a cure for epilepsy. It is put out by the Nobro Medic Co., Worthington, Ohio, and sold on the mail-order plan. The individual behind this concern seems to be one Harry M. Freck, whose claim to medical knowledge appears to be based on the fact that he once operated the Freck Garment Company, and at present conducts the Freck Stenographic Bureau and an advertising circular-letter business. He has been connected with other "patent" medicines. Nobro comes in the form of pink capsules. The "course" consists of ninety capsules sold for four dollars. The American Medical Association Chemical Laboratory analyzed Nobro and reports that each capsule contains essentially 0.0414 Gm. (approximately 3/5 grain) of phenobarbital to which has been

added lactose. (*Jour. A. M. A.*, January 7, 1928, p. 49).

Desiccated Parathyroid Gland Preparations Omitted from N. R. R.—The general article Parathyroid Gland, in New and Nonofficial Remedies, 1927, states that there is no conclusive evidence for the oral use of parathyroid gland preparations. In 1926 the Council decided to omit all such preparations with the close of 1927 unless in the meantime evidence should develop to show that they were effective. No such evidence has developed. On the contrary, evidence in the opposite direction has become available. Accordingly, the Council directed the omission of all the accepted brands of desiccated parathyroid gland from New and Nonofficial Remedies. (*Jour. A. M. A.*, January 14, 1928, p. 117).

Aseptones Not Acceptable for N. R. R.—The Council on Pharmacy and Chemistry reports that under the noninforming but therapeutically suggestive name "Aseptones," the Scent-Ets Company, Brooklyn, markets a mixture stated to have the following composition: menthol, 0.40; salicylic acid, 2.00; sodium chloride, 60.00; zinc sulphate, *dried*, 65.00; alum, *dried*, 65.00; boric acid, granular, to make 500.00; tincture of cudbear, 2 cc. The preparation is referred to as "the astringent and antiseptic Douche Powder." The Council found "Aseptones" unacceptable for New and Nonofficial Remedies because it is an unscientific mixture, marketed under a noninforming, therapeutically suggestive name, and without declaration of its quantitative composition. (*Jour. A. M. A.*, January 14, 1928, p. 117).

The Dangers of Ultraviolet Rays—Not only do barber shops swindle prospective victims of baldness with incandescent lamps colored purple, not only do electrical corporations sell, as ultraviolet ray devices, contraptions delivering hardly any ultraviolet radiation at all, but some manufacturers of apparatus actually delivering ultraviolet rays of potency endeavor to place these devices wherever a sale can possibly be made. Regardless of the fact that practically every method in medicine that may do good, can also do harm, these machines are being sold to bath institutes, swimming pools, massage parlors, beauty parlors, clubs, barber shops and innumerable other businesses in which medical supervision is certainly not probable, indeed, hardly possible. The sales are made notwithstanding the fact that scientific literature has already revealed that the rays may in some instances be potent for harm. (*Jour. A. M. A.*, January 14, 1928, p. 120).

John R. Brinkley—Quack.—In and from the little village of Milford, Kansas, John Richard Brinkley demonstrates the commercial possibilities of "goat-glands." He obtains his publicity through sensational articles in newspapers and by means of the privately owned radio broadcasting station KFKB. Those who write to the station are immediately put on the Brinkley "sucker list" and receive miscellaneous printed matter and a follow-up series of letters that, seemingly, never end. One of the advertising booklets sent out by Brinkley is entitled "The Compound Operation, or The Modern Passport to Successful Rejuvenation." It is claimed that "the Compound Operation is the best thing known for Impotency, high blood pressure, enlarged prostate, sterility (anastamosing operation), Neurasthenia, Dementia Praecox, or any disease that is not malignant of the prostate." Those who get on the "sucker list" are urged to make reservations in the Brinkley "hospital" at the earliest possible time. Brinkley also has a "Special Gland Emulsion" which is another means of separating seekers of rejuvenation from their money. This is sold on the mail-order plan and one month's supply costs $100. (*Jour. A. M. A.*, January 14, 1928, p. 134).

Diphtheria Toxoid (Anatoxine-Ramon). — This product, as prepared at the serum division of the Pasteur Institute by Dr. Ramon himself, has been successfully employed in immunization against diphtheria in France and other countries. No information is at hand as to the efficacy and safety of commercial preparations of diphtheria toxoid made in this country. The Council on Pharmacy and Chemistry of the American Medical Association has not accepted any of these preparations for inclusion in New and Nonofficial Remedies. (*Jour. A. M. A.*, January 14, 1928, p. 139).

Erusticator.—The American Medical Association Chemical Laboratory reports on the composition of a poisonous rust remover. A physician had reported the death of a baby, who had died ten minutes after biting into a tube of "Erusticator." The product is put out by the Sterling Products Company of Easton, Pa. It was not labeled "Poison." Analysis showed that the preparation was essentially an aqueous solution of a mixture of ammonium and hydrogen fluoirdes (generally designated as ammonium bifluoride) equivalent to 26.3 per cent ammonium fluoride, and 16.9 per cent hydrogen fluoride. The sale of such poison without fair warning to the consuming public is to be deprecated. (*Jour. A. M. A.*, January 21, 1928, p. 205).

Solvo Aspirin Not Acceptable for N. R. R.—Solvo Aspirin (Ess & Arch Co., Philadelphia) bears the declaration on the label that "Each teaspoonful contains 5 grains of aspirin in a soluble and convenient form with other suitable ingredients." In the information sent the Council on Pharmacy and Chemistry the following statement of composition was offered: "Solvo Aspirin is a solution containing five grains of ASPIRIN (Acetylsalicylic Acid) to each fluid dram, in a soluble form free from all precipitates combined with Glycerine, Elixir Aromatic, Distilled Water and Tincture Cudbear." In another communication, the preparation was declared to contain, in addition, two grains of sodium bicarbonate to each teaspoonful. The Council reports that from the information it is evident that the preparation is one in which the attempt is made to make acetylsalicylic acid more soluble by addition of sodium bicarbonate, and this despite the fact that it is well known, that, in the presence of water, acetylsalicylic acid reacts with sodium bicarbonate to form sodium acetylsalicylate, which in turn is hydrolyzed to sodium acetate and sodium salicylate. In consonance with this, the American Medical Association Chemical Laboratory reported that in a specimen submitted to examination, the acetylsalicylic acid was largely, if not completely, decomposed into sodium salicylate and sodium acetate. The Council declared Solvo Aspirin unacceptable for New and Nonofficial Remedies because it is an unscientific mixture, marketed under a misleading name, with an incorrect statement of composition and with unwarranted claims. (*Jour. A. M. A.*, January 21, 1928, p. 205).

Laxative Action for Bran.—Experiments on the laxative action of wheat bran showed that this was due to the crude fiber (cellulose) which it contains. This crude fiber was found to be feces-forming; it had the power of producing more than its own weight of feces. This presumably takes bran out of the category of drugs and properly relegates it to the kitchen. Indeed, it has been suggested that only through use in the more palatable forms of cookery does bran really "cure" or take care of constipation. Even, so, it has many limitations. (*Jour. A. M. A.*, January 21, 1928, p. 206).

Some Effects of Synthalin.—Investigation by Blatherwick and his colleagues at the Santa Barbara Cottage hospital in California demonstrated that synthalin administered by stomach tube failed to produce hypoglycemia in rabbits. Subcutaneous and intravenous injections usually decreased the blood sugar. Acute nephritis is produced by parenteral administration. There is also injury of the liver, as shown by a decreased ability to deaminize subcutaneously injected glycine. Certainly caution should be exercised in the use of a drug showing such properties, Blatherwick points out that the hypoglycemia produced by synthalin may be due to a combination of at least two processes. One of these re-

(Continued on adv. page xx)

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TRUTH ABOUT MEDICINES

(Continued from page 136)

sembles the action of insulin and the other that of hydrazine. The latter substance appears to cause hypoglycemia by injuring the liver and thus preventing normal glyconeogenesis. Synthalin has apparently not yet met the prerequisites for rational use in the relief of diabetes. (*Jour. A. M. A.*, January 21, 1928, p. 209).

More Misbranded Nostrums.—The following products have been the subject of prosecution by the Food, Drug and Insecticide Administration of the United States Department of Agriculture which enforces the Federal Food and Drugs Act: Chi-Ches-Ter's Diamond Brand Pills (Williams Manufacturing Company), containing iron sulphate and some vegetable drugs, including aloe. Depurativo Ruso Makharoff (Porto Rican American Drug Company), consisting essentially of potassium iodide, mercuric iodide, sodium sulphate, sarsaparilla extract and water. Malt-O-Cod (Fred Stearns), consisting essentially of sugar, alcohol and water, extracts of plant drugs, including quinine and strychnine, with compounds of phosphorus, iron, calcium, sodium and potassium, and a very small quantity of salicylates. Phosphated Iron (Relief Laboratory, Inc.), consisting essentially of iron phosphate and carbonate, nux vomica extract and a laxative drug. Inyeccion Roja Martinez (Porto Rican American Drug Company), consisting essentially of zinc phenolsulphonate, alum, catechu and water. Alvita Tableta and Alvita Tea (California Alfalfa Products Company), the first containing vegetable extractives, oil of sassafras and celery, while the second consisted of ground alfalfa. Walnut Wine Prieto (Vino De Nogal) (Indian Laboratory Company), consisting essentially of a water-alcohol solution of sugars, glycerine, caramel, strychnine and plant material. Life Saver (M. Arizpe), an alcohol-water solution of sugars, glycerine, acetic acid, saponin-like glucoside, and plant extractives. Amargo De Agave (Regional Medicine Company), an alcohol-water solution containing potassium iodide and plant drugs, including sarsaparilla. (*Jour. A. M. A.*, January 21, 1928, p. 222).

Effects of Spring Waters.—The waters of Hot Springs, Virginia, are alkaline, earthly and sulphated, at temperature of from 108 to 112 F. Those of Hot Springs, Arkansas, are also alkaline and earthy, ranging in temperature from 76 to 148 F. The heat at which these waters are used is no doubt their most potent influence. These waters are radioactive, but a government expert after making an extensive survey of radioactive mineral waters concluded that up to this time it has not been shown that the small amounts of radioactivity found in natural waters have any effect on the medicinal value of the waters. (*Jour. A. M. A.*, January 21, 1928, p. 225).

Tophirin Tablets Not Acceptable for N. R. R.—The Council on Pharmacy and Chemistry reports that "Tophirin Tablets" (Bram Chemical Co., Philadelphia) is stated to contain in each tablet: "Acid Phenyl Cinchoninic (cinchophen) Gr. 3½; Magnesium Salicylate Gr. 3½; Colchicine, Alkaloid Gr. 1/400" but that no quantitative statement appears on the package or in the advertising. In the administration of cinchophen, the salicylates, and colchicum it is essential that these drugs be given in amounts suited to the individual case and patient. There is no evidence showing that the combined use of these drugs is of advantage. It is thoroughly irrational to administer cinchophen, magnesium salicylate and colchicine in fixed proportion. The Council found "Tophirin Tablets" unacceptable for New and Nonofficial Remedies because it is an irrational mixture offered to the profession without declaration of its quantitative composition and under a name which does not declare the potent ingredients but is therapeutically suggestive, and because it is sold with unwarranted claims and in a way which will lead to its ill-advised use by the public. (*Jour. A. M. A.*, January 28, 1928, p. 293).

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ORIGINAL ARTICLES

THE DIAGNOSIS AND TREATMENT OF ACUTE INFECTIONS OF THE HAND*

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CHICAGO

I wish first of all to express my appreciation of your courtesy in asking me to speak to you this evening, and secondly to express my great obligation to my teacher and preceptor, Dr. Allen B. Kanavel, for the knowledge I have gained, during an association of nearly twelve years, of the subject of infections of the hand. I once heard a distinguished surgeon in one of our southern cities say to a class of students that he considered Kanavel's book on infections of the hand[1] one of the few great monographs of modern medicine. I have studied this monograph and reread it many times, and the principles I wish to stress and the cases which illustrate them are based upon that study.

Infections of the hand may be divided into five groups, according to the anatomical structures involved. These are lymphatic infections, infections of the subcutaneous tissue spaces, infections of the tendon sheaths and their prolongations in the forearm, infections of the fascial spaces of the hand, and infections of the bones and joints of the hand and wrist. A severe infection may involve a number of anatomical structures, but for purposes of discussion the division is of value.

Lymphatic Infections: Lymphatic infections usually follow a trifling injury—the stick of a pin, a scratch from a rusty nail, a hair follicle infection, an injury from a surgical needle or tonsil snare. They may rapidly give rise to systemic symptoms, such as a chill, a high fever and prostration.

To appreciate the importance of such infections one must remember that the lymphatics of the hand are small and numerous, and cover the hand like a fine meshwork. Of particular interest and importance is the fact that the lymphatic channels *take the shortest course to the back of the hand.* From the back of the hand the lymphatics are drained through several larger lymphatic channels that extend upward to the axilla. The lymphatic vessels from the little finger and ring finger usually drain into the antecubital and epitrochlear glands, so that these glands may be involved early in infections involving the ulnar side of the hand. The lymphatics of the thumb and index finger usually drain directly into the axillary glands, so that in infections of the radial side of the hand the axillary glands are the first to be involved. Infections of the middle finger may drain into either the antecubital or axillary glands, but in fifteen percent of cases, according to Kanavel, drain directly into the supraclavicular glands, so that infection arising in the middle finger may very early produce severe systemic symptoms.

Involvement of the lymphatics with red streaks running up the forearm and early involvement of the glands are danger signals—warnings of an acute fulminant infection, usually of the streptococcic type. Such infections require immediate and watchful care—rest in bed, large quantities of fluids, careful elimination, big hot dressings covering the entire extremity and most conservative surgical treatment, *i. e.,* incision only when there is definite localization of the infection.

The danger of hasty incision in this type of infection is illustrated by a case which came under our observation two years ago. A junior medical student in his service at the lying-in dispensary infected a scratch wound on the dorsum of the index finger. The finger became somewhat swollen and painful, and he persuaded one of the surgeons in the out-patient department to incise it under a local anesthetic. No pus was found. The following day the finger was more swollen and painful; there were a few red lines running up the forearm and the patient was obviously ill. He was told to go to bed, to drink a lot of water, to put a big, hot dressing on the forearm, and that under no circumstances must anyone be allowed to incise the finger. He rather protested against this advice; he still thought there was pus in the finger, but because he assured us that he would carry out the treatment at home and that he could do it very much more conveniently than by entering the hospital, he was permitted to go home. Nothing was heard from him, and the matter was forgotten

*From the Department of Surgery, Northwestern University Medical School. Read before the Academy of Medicine of Cincinnati, January 30, 1928, and the Elkhart County Medical Society, Elkhart, Indiana, February 2, 1928.

until ten days later when, in glancing at the bulletin board, I saw a notice that the junior class was excused from classes to attend the funeral of this boy. He had gone home from the hospital, persuaded a neighborhood doctor, whom he assisted during his spare hours, to incise the finger, and within twenty-four hours had developed a severe chill, a temperature of 105 degrees, and all the

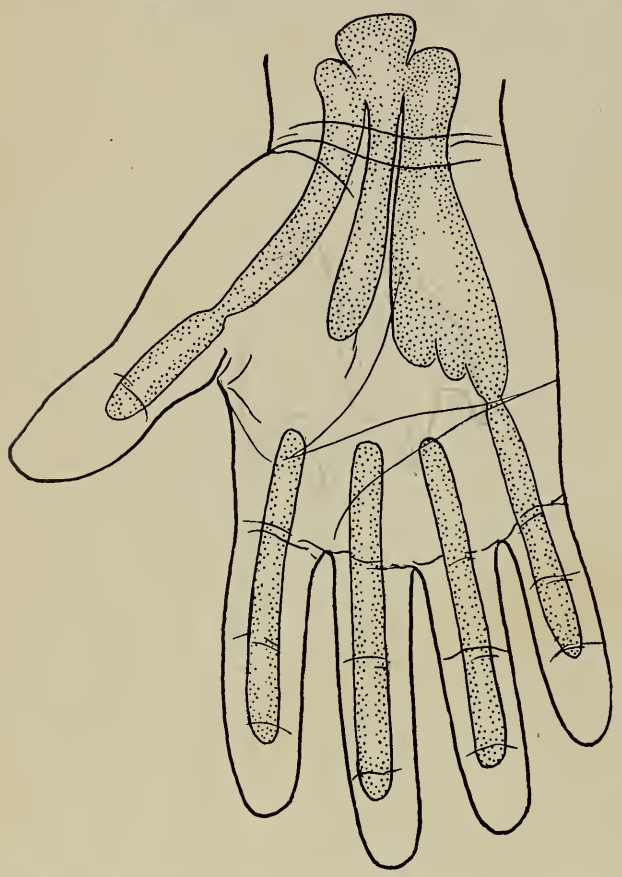


Fig. 1. The relation of the flexor tendon sheaths and the radial and ulnar bursae to the superficial markings of the hand.

signs of a malignant generalized infection. Within two days symptoms of pulmonary involvement appeared and the condition rapidly went on to a fatal termination.

In such cases if one cannot succeed in bringing about a localization of the infection by conservative treatment, he may be certain that surgical intervention will only hasten the fatal outcome.

Infections of the Subcutaneous Tissues: Of the subcutaneous tissues the distal phalanx is most frequently involved and in the development of such infection the anatomical structure plays an important part. The connective tissue of the terminal phalanx constitutes a more or less closed chamber which includes the diaphysis of the bone. Running vertical to the surface of the skin in the pulpy, subcutaneous tissue of the palmar surface are fibrous septa which subdivide this chamber into several compartments. Between the fibrous septa are glands and columns of fat. Infection introduced into this space from without tends to remain and develop *in situ* since the thick, dense palmar skin prevents its escape. Such infection may involve the diaphysis of the bone at an early stage because the glands and columns of fat form a direct medium for the extension of infection, and since infection under tension in the closed space tends to compress the digital blood vessels and shut off the blood supply of the bone.

The early symptoms of such an infection are intense, throbbing pain, swelling, tension and other signs of inflammation involving the distal phalanx. Within a few days the pain may subside and the distal phalanx be transformed gradually into a bluish, distended, swollen mass. Later a sinus forms and continues to discharge pus. Such an infection is differentiated in its early stages from an acute lymphangitis by the excessive tension, almost board-like induration, and by the limitation of the tension and swelling to the distal phalanx, in contrast with the diffuse involvement of the entire finger associated with a spreading lymphatic infection.

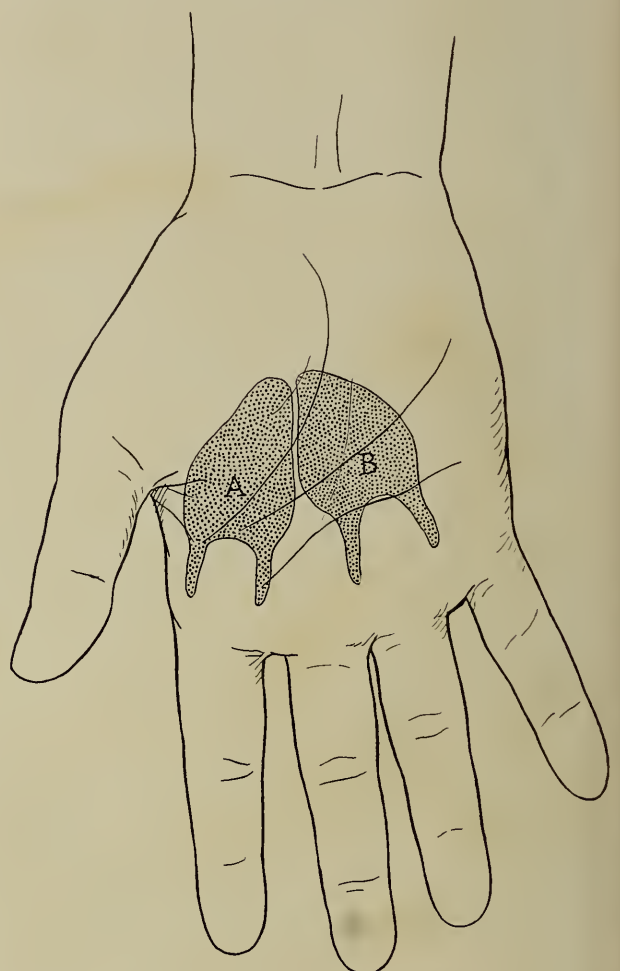


Fig. 2. Diagram of an x-ray picture of a hand in which the thenar and middle palmar spaces have been filled with a bismuth paste. (*After Kanavel*).

Unless such an infection is drained promptly and effectively, osteomyelitis is almost certain to occur. Even if it does occur the epiphyseal end of the bone is usually not involved early in the disease nor is the tendon of the flexor profundus, which is inserted upon it.

The treatment of such an infection is incision

and drainage at the earliest possible moment. To apply hot dressings and wait for the infection to "come to a head" is to cause the patient unnecessary hours of intense suffering and permit more extensive necrosis to take place. Adequate drainage can be secured by an incision on one side of the affected phalanx if the incision is sufficiently large and if it divides the fibrous septa mentioned above. Care must be taken not to penetrate the tendon sheath as it covers the insertion of the deep tendon at the base of the distal phalanx. If osteomyelitis has developed the necrotic bone should be removed with the greatest possible care so as not to injure the upper, epiphyseal end of the phalanx. The horse-shoe shaped incision over the end of the finger should be avoided because it is unnecessarily large, is slow in healing, and leaves a tender scar over the sensitive tip of the finger.

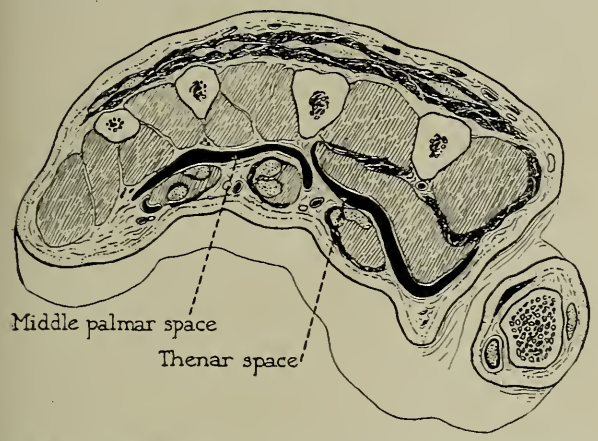


Fig. 3. Cross-section of the hand, above the metacarpo-phalangeal joints, to show the relation of the thenar and middle palmar spaces and of the dorsal fascial spaces to the surrounding tissues. (*After Kanavel*).

A second type of superficial infection, and one which may lead to a long-drawn-out convalescence, is the simple paronychia. The infection usually begins at the side of the nail, the tissues about the nail become red and swollen, a little pus is discharged from a tiny opening at the side of the nail, and the whole affair seems very trifling. Unfortunately, however, the condition may progress; the tissues become bluish and swollen, granulation tissue develops about the site of infection and the patient begins to lie awake at night with a throbbing pain out of all proportion to the objective symptoms present. The site of infection is under the nail and the throbbing pain is due to the fact that it is held there under tension. Because of the proximity of the bone to the nail bed, secondary osteomyelitis may develop very easily.

Once the infection has extended underneath the nail an incision should be made at each side of the nail, the eponychium lifted up from the proximal portion of the nail, and the proximal portion of the nail amputated with sharp scissors. A little packing may be placed underneath the eponychium to hold it away from the nail bed for twenty-four or forty-eight hours and thus favor drainage. In making the incisions at the side of the nail one should be careful to cut well to the side of the nail. If the nail bed is once divided with the knife an unsightly split finger nail will result.

A third type of subcutaneous infection is the so-called collar button abscess, which occurs frequently in workingmen with calloused hands. Infection finds its way into the subcutaneous tissues through a fissure or crack just above the web of the fingers. A small pocket is formed underneath the epidermis, but since the overlying skin is so thick and firm the pus cannot force its way to the surface, it spreads more deeply, and, in the characteristic form, it extends through or below the transverse fibers of the palmar fascia that form the web of the fingers. Under such conditions the involved area, the tissue between the adjacent fingers, and particularly the soft elastic tissue on the dorsum, become swollen, tense, indurated. If a yellowish discoloration is seen through the superficial callus, an incision is made on the palmar surface and a small pocket of pus is opened. Unless one remembers that the larger pocket of pus lies more deeply, often on the dorsal aspect of the superficial transverse ligament, he will not secure adequate drainage.

Tendon Sheath Infections: Tendon sheath infections may result from direct inoculation or from extension of infection from the subcutaneous tissues. Their gravity lies in the fact that infections within the tendon sheath spread with remarkable rapidity, and that destruction of the tendon sheath and of the tendon itself ensues in a very short time unless the infected area is drained and prompt measures instituted to maintain the function of the tendons.

The tendon sheaths of the index, middle and ring fingers extend from a point just distal to the distal flexion crease of the finger to a line closely approximating the distal flexion crease of the palm (Fig. 1). They lie in close apposition to the palmar surface of the phalanges and are separated from the bone only by a thin layer of connective tissue. Opposite the proximal interphalangeal



Fig. 4. The characteristic deformity present in an infection of the thenar space.

joint, particularly, there is very little tissue intervening between the tendon sheath and the bone. An infection of the flexor sheaths of any of these fingers makes itself evident very promptly by swelling, inability to extend the fingers completely and by tenderness which corresponds definitely and accurately to the anatomical outlines of the tendon sheath.

The sheath of the long flexor of the thumb begins at a point slightly distal to the distal flexion crease of the thumb, and accompanies the



Fig. 5. Lines of incision for drainage of the tendon sheaths.

flexor pollicis longus through the palm to terminate a thumb's breadth above the anterior annular ligament in an expansion known as the radial bursa. (Fig. 1). Over the first metacarpal bone it lies between the flexor pollicis brevis and the adductor obliquus. The motor branch to the muscles of the thenar eminence lies superficial to the tendon sheath, approximately a thumb's breadth above the annular ligament. The bursa ends in a blind pouch under the tendon and upon the pronator quadratus, separated by the latter from the wrist joint and the radio-ulnar joint.

The tendon sheath of the flexors of the little finger begins just distal to the distal flexion crease of the fifth finger and extends proximalward to become continuous, in the majority of cases, with the ulnar bursa, a good sized sac which lies over the metacarpal bone of the ring finger and the head of the middle metacarpal bone, and extends proximalward under the anterior annular ligament a thumb's breadth above the ligament (Fig. 1). Here it lies underneath the flexor tendons, upon the pronator quadratus muscle, and is separated by this muscle from the wrist joint. In the region of the wrist joint the ulnar bursa forms a more or less complete sheath for the flexor tendons, being pushed radialward, as it were, in three pockets—one superficial to the tendons, one between the superficial and deep tendons and one, the largest and most easily distensible, underneath the deep tendons.

The exact arrangement of the tendon sheaths in the proximal portion of the palm and over the wrist is subject to considerable variation. The important fact from a practical standpoint is that in the majority of instances the radial and ulnar bursæ communicate with one another by way of an intermediary sheath, so that an infection of the tendon sheath of the thumb and radial bursa extends to the ulnar bursa and distally along the tendon sheath of the little finger. An infection arising in the tendon sheath of the fifth finger involves the same structures in the reverse order. From these various sites infection may extend to a number of different places, as will be indicated later.

The flexor sheaths of the dorsum are relatively unimportant from a surgical standpoint. There are six, one for each of the tunnels under the posterior annular ligament. They end three or four centimeters distal to the ligament.

The diagnosis of a tendon sheath infection is based on symptoms which early in the course of the infection are limited to the area involved, but which tend very quickly to become more difficult of interpretation because of extension of the infection to surrounding tissues. These symptoms are pain, tenderness and other signs of inflammation, frequently quite out of proportion to the extent of the infected area. The patient holds the affected finger in a slightly flexed position. Any attempt to extend it causes him to wince with pain. By gentle pressure with a pencil or similar blunt instrument an area of tenderness may be outlined which corresponds accurately to the anatomical outline of the tendon sheath. In infections of the fifth finger Kanavel has pointed out that a point of maximum tenderness may be found just proximal to the point where the distal flexion crease of the palm crosses the flexor tendons of the fifth finger. At this point the tendon sheath lies close to the surface and is not covered by overlying muscles. In every case the dorsum of the affected finger is swollen and edematous because of the direction of lymphatic drainage.

If the infection involves only the index, middle or ring finger there is no doubt as to its location and the freedom of other fingers from infection.

With infection of the radial and ulnar bursa the inflamed swollen wrist, with the tense anterior annular ligament drawn like a taut cord across its volar surface, suggests at once the extension of the infection into the forearm. If the infection has begun in the thumb and spread into the radial bursa it may occasionally be difficult to determine whether the ulnar bursa and the tendon sheath of the fifth finger are involved. In such a case the position in which the fifth finger is held, the presence of pain on attempted extension of the finger, and the presence of the point of maximum tenderness mentioned above are important considerations. If there is still doubt it is wise through a bloodless field to make an exploratory incision in the palm over the sheath of the flexor tendons of the fifth finger. If no infection is present no harm will be done by such a procedure, but irreparable injury may be done if the infected area is not properly drained. If the primary infection involves the tendon sheath of the fifth finger the same considerations apply in a reversed order with reference to the radial bursa and the flexor tendon sheath of the thumb. Since in more than eighty percent of cases the radial bursa communicates with the ulnar bursa above the wrist it is common to find involvement of both.

In cases which have been neglected for four or five days, or which have been inadequately drained, the median and ulnar nerves may be so compressed by the pressure of the exudate above the wrist as to be partially anesthetized. In such cases the characteristic symptoms mentioned above—particularly the excruciating pain caused by forced extension of the affected fingers—are masked, but the history, the location of the primary lesion, the bulging swelling above the wrist, and the general symptoms of severe infection make the diagnosis clear.

When rupture takes place from the tendon sheaths of the index, middle or ring fingers the pus spreads into one of the fascial spaces of the palm, and forms an abscess of the thenar space or the middle palmar space. (These will be discussed under infections of the fascial spaces.) When rupture takes place from the radial or ulnar bursæ the pus at first lies between the flexor tendons and the pronator quadratus. As it spreads upward it dissects between the superficial and deep flexor muscles and tends to become superficial along the ulnar side of the upper third of the forearm. In such an event the entire hand and forearm are dusky red, swollen, tense and edematous. Vesicles or blebs may cover large areas of the affected extremity. Because of the extent of the involvement and the retention of a large amount of pus under pressure toxic absorption proceeds at a rapid rate and the general symptoms of severe infection—high fever, rapid pulse, profuse perspiration, prostration, and not uncommonly delirium—indicate the extreme gravity of the condition.

The Fascial Spaces of the Hand: These include the thenar space, the middle palmar space, the lumbrical spaces which extend distalward from the thenar and middle palmar spaces along the lumbrical muscles and the fascial spaces of the dorsum of the hand. Infection of the fascial spaces of the palm may occur by direct inoculation and as the result of deep penetrating wounds, but most commonly occurs as the result of extension of a tendon sheath infection.

The thenar space lies upon the adductor muscles of the thumb partially covered by the short muscles of the thenar eminence, by the flexor tendons of the index finger and by the accompanying digital vessels and nerves (Fig. 2, A; Fig. 3). It extends ulnarward to the middle metacarpal bone. The middle palmar space lies deep in the palm upon the interosseous muscles, underneath the flexor tendons of the middle and ring fingers (Fig. 2, B.; Fig. 3). On the radial side it is bounded by the middle metacarpal bone. On the ulnar side it is partially covered by the overlying distal end of the ulnar bursa.



Fig. 6. Line of incision for drainage of the middle palmar space.

Tendon sheath infections arising in the index finger tend to rupture into the thenar space. Tendon sheath infections arising in the middle and ring fingers usually rupture into the middle palm-

ar space. In neglected cases tendon sheath infections starting in the thumb may rupture into the thenar space, and tendon sheath infections arising in the fifth finger into the middle palmar space. With pus under great tension rupture from one space into the other may take place.

The symptoms of thenar space infection are pain, tenderness and swelling of the



Fig. 7. Line of incision for drainage of the thenar space.

thenar eminence. Normally the thenar eminence is the most prominent portion of the palm, but with infection in the thenar space it stands out in such a pronounced fashion as to elevate the thenar eminence still more above the remainder of the palm and give a peculiar distorted appearance to the hand (Fig. 4). The dorsum of the web between the thumb and index finger is swollen and edematous. With pus under tension there is extension of the infection along the lumbrical space on the radial side of the index finger, with tenderness and swelling on the dorsum of the tissues between the index and middle fingers.

With infection of the middle palmar space the striking symptoms are the loss of the normal concavity of the palm and the edema and swelling of the dorsum of the hand. Because the pus lies under the flexor tendons and the firm palmar fascia the palmar swelling is not pronounced, but it is sufficient to change the normal concavity of the palm into a slight convexity. Because of the direction of lymphatic drainage the dorsum of the hand is swollen and edematous, but pus will not be found on the dorsum except in those neglected cases in which the infection has extended distalward along the lumbrical spaces between the third and fourth and fourth and fifth fingers and passed to the dorsum in the subcutaneous tissue about the web of the fingers. Only in grave, neglected infections in which osteomyelitis has taken place does pus find its way through the barrier of deep fascia, interosseous muscles, and metacarpal bones from the palm to the dorsum of the hand.

On the dorsum of the hand are two definite fascial spaces, the one superficial and the other deep to the extensor tendons and the fibrous tissue that unites them into a single layer or aponeurosis (Fig. 3). Infection of the superficial tissue of the dorsum is usually the result of a hair follicle infection. It may spread lateralward rapidly, and because of the great number of lymphatic vessels extending proximalward it may very quickly give



Fig. 8. Aluminum splint for maintaining the hand in the position of function during the period of healing.

rise to red lines of lymphatic extension upon the dorsum of the forearm. Such an infection does not tend to extend deeply because the lines of lymphatic drainage run in a different direction.

Infections of the subaponeurotic space result from penetrating wounds, from injuries, and from injudicious incision of superficial infections. Their gravity lies in the fact that there is no barrier to

their extension across the entire dorsum of the hand, and in their proximity to the metacarpal bones. With such infections the wound of entrance is often small and easily blocked. In the absence of free drainage to the surface the infectious material spreads underneath the extensor tendons from one side of the hand to the other. Necrosis of the tendons and secondary osteomyelitis give rise to persistent swelling and long continued discharge which can be relieved only by adequate drainage and removal of necrotic tissue.

Treatment of Tendon Sheath and Fascial Space Infections: The treatment of infections of the tendon sheaths and fascial spaces is to secure adequate drainage as soon as the condition is recognized. This should be done under a general anesthetic such as nitrous oxide, ethylene or ether, and through a bloodless field secured with the aid of a constrictor.

In draining the tendon sheaths of the fingers the incision should be made well to the side of the finger (Fig. 5), so as to avoid the digital nerves and blood vessels, the flexion creases on the palmar surface, and so as to prevent herniation of the tendon from its sheath, a complication that occurs very promptly if the sheath is opened through the middle of the palmar surface of the finger.

On incising a finger with infection of the tendon sheath one is always surprised by the extensive swelling of the subcutaneous tissues, and by the manner in which they seem to fill the entire wound and obstruct the deeper structures from view. Unless this edematous tissue is well retracted it is impossible to secure a clear view of or even to expose the deeply lying tendon sheath. If one can expose the sheath for a little distance before nicking it with the scalpel he will find, instead of a thin translucent membrane through which the shining tendon may be discerned, a grayish edematous structure which resembles the edematous peritoneum overlying an appendiceal abscess. The moment it is opened the pus pours out. In very early cases the pus may not yet fill the sheath, and may appear only when the tendon is raised from the posterior surface of its sheath.

If the flexor sheaths of the thumb and little finger are involved the incisions must be extended upward (Fig. 5). One should avoid cutting through the muscles of the thenar eminence in the case of the thumb by making a curved incision to the ulnar side of the thenar eminence and retracting the thenar muscles radialward, and should remember that the flexor tendons of the little finger run obliquely upward and radialward and not in the line of the fifth metacarpal bone. Such an infection also requires an incision on the ulnar side of the forearm to drain the upper, most distensible portions of the ulnar and radial bursæ (Fig. 5). It should always be made at the side, never over the middle of the volar surface, for the pus lies underneath the flexor tendons. A median incision in such a case inevitably leads to extensive fibrosis and destruction of tendons and frequently to operative or postoperative injury of the median nerve (Fig. 10).

In draining the middle palmar space (Fig. 6) the flexor tendons, digital nerves, and blood vessels of the middle finger should be retracted to the radial side and the corresponding structures of the ring finger to the ulnar side. The middle palmar space, as it lies behind the flexor tendons, will then be widely exposed. Occasionally an additional incision over the lumbrical canal of the ring finger helps to make drainage more complete and hasten recovery. Through the incision indicated for drainage of the thenar space (Fig. 7) a pair of forceps or Kocher dissector may be passed upward and ulnarward directly into the abscess cavity as it lies upon the adductor muscle of the thumb.

If drainage incisions are correctly located and of adequate length, an incision on one side of the affected fingers and on the ulnar side of the forearm, in the case of ulnar and radial bursa infections, suffices for drainage. The use of through-and-through drainage above or underneath a flexor tendon should be carefully avoided. It is the surest possible method of causing necrosis of the tendons.

With infections of the middle palmar and thenar spaces, drains should never be inserted through and through from the palm to the dorsum of the hand. The spaces in question are separated from the dorsal surface by a number of anatomical layers (Fig. 3). To plunge a pair of forceps through the deep volar fascia, the interosseous muscles, between metacarpal bones and through the dorsal aponeurotic and subcutaneous layers in order to drain an accumulation of pus in one of the fascial spaces of the palm is to show a complete disregard for the principles of surgical treatment and to render almost certain the development of osteomyelitis and the formation of persistent sinuses.

With infections of the dorsum of the hand adequate drainage should be instituted directly over the site of infection. The cases most difficult of treatment are those in which an infection of the subaponeurotic space has developed. Unless free drainage is instituted the infection spreads under the aponeurosis from one side of the hand to the other and osteomyelitis of the metacarpal and carpal bones is almost certain to occur.

Infections of the Bones and Joints: Acute and subacute osteomyelitis most commonly result from traumatic amputations and from imperfectly drained infections of the soft tissues. Osteomyelitis of the distal phalanx has been mentioned above in connection with felons and paronychia. Osteomyelitis of the middle phalanx, as has been pointed out by Kanavel, is a frequent complication of infection of the flexor tendon sheaths, because of the intimate relation between the flexor sheath

and the middle phalanx. Diffuse involvement of the carpal bones develops early in imperfectly drained infections of the radial and ulnar bursæ. Bone involvement should always be suspected in the presence of persistent pain and wound discharge which is undiminished in spite of free drainage of the soft tissues. It may be diagnosed with certainty if through-and-through drains have been used in the drainage of a palmar abscess. In the early stages decreased density of the bone shadow in the x-ray picture, and in the later stages erosion and irregularities in the contour of



Fig. 9. The functional result in a patient with infection of the radial and ulnar bursae which had ruptured into the forearm.

the bone shadows help to make the diagnosis certain.

Acute pyogenic arthritis is usually due to a penetrating wound close to or involving the joint, or to acute suppurative processes involving the tendon sheaths or fascial spaces which have been improperly drained. It is characterized by local signs of acute inflammation centering about the affected joint, by loss of function, and by exquisite pain on attempted movement. So definite are these symptoms that there is rarely any doubt in an acute case as to the presence of joint involvement.

Aside from suppurative arthritis due to direct trauma or to wounds contiguous to the joint, the type of acute monarthritis most commonly seen is that due to gonococcal infection of the wrist joint. This type of joint infection develops suddenly, with or without a predisposing injury, is accompanied by swelling, redness, heat, by marked pain and tenderness, and by excruciating pain on attempted movement. Accompanying it there is often so marked an edema of the back of the hand that at first glance one is likely to think of a palmar abscess; but the absence of tenderness over the palm, the retention of the normal contour of the palm, and the absence of pain on gentle movement of the fingers (not the wrist) help to localize the lesion to the wrist joint. At times it is possible to aspirate a dark straw colored or blood tinged fluid from the wrist joint. Accompanying the local symptoms there may be a moderate pyrexia; and almost always it is possible to demonstrate a genital focus of gonococcal infection.

Except in the gonococcal form of monarthritis the essential treatment of acute osteomyelitis and arthritis of the hand, as elsewhere in the body, is adequate drainage. The details of treatment are so well known that further discussion is unnecessary.

After Treatment of Hand Infections: In order to stop venous oozing after operations on the hand and to keep wound edges widely separated drainage wounds are lightly packed with gauze impregnated with petrolatum. Occasionally rubber tissue is used instead. Tubes are never used because pressure necrosis of tendons and tendon sheaths and extensive fibrosis involving tendons and nerves inevitably result from their use.

In dressing the hand a large sterile towel is laid on the arm board, covered with abdominal pads and sterile dressings and the outstretched arm is laid on the bed of dressings. More dressings are



Fig. 10. The result in a patient with a neglected tendon sheath infection which was permitted to go on to destruction of all the flexor tendons, of the median and ulnar nerves. (Note the deformity resulting from the incisions made for drainage.)

added to cover the arm, the dressings are saturated with a hot sterile boric or salt solution and the edges of the towel brought together to enclose the whole. The hot solution or sterile water is added at two-hour intervals without changing the dressing and a powerful electric light is suspended above the arm to help maintain the heat.

At the end of twenty-four hours the dressings

are removed and a sterile dressing reapplied with the same care that was used in applying the original dressing. If one can avoid adding secondary infection, particularly to streptococcic infections of the tendon sheaths, as has been so well shown by Cleveland[2] and by Garlock[3], the tendons may be saved and a complete restoration of function secured in a considerable proportion of cases.

The petrolatum gauze is removed at the first or second post-operative dressing. No drainage material is reinserted after removal of the original drains.

As soon as the acute symptoms have subsided, usually at the end of three or four days, an arm bath, used for fifteen or twenty minutes twice daily, is substituted for the continuous moist dressing. After being soaked in a hot sterile solution the arm is laid on a sterile towel, allowed to dry for a half hour under an electric light and covered with a dry dressing. While the hand is in the bath the patient is urged to move his fingers gently to prevent the formation of fibrous adhesions. Simply moving the fingers through their complete range of motion once or twice daily during the period of forced immobilization will suffice to prevent the formation of crippling adhesions. In addition to the dry dressing a light aluminum splint is applied to maintain the hand and the fingers in the position of function[4] (Fig. 8). As soon as the danger of lighting up the infection has passed physical therapy and active exercises are begun so that restoration of function may keep pace with the healing of the tissues[5] (Fig. 9).

In neglected cases in which extensive contractures have been allowed to develop, often because of prolonged immobilization of the hand in a big moist dressing with the fingers extended and the thumb lying alongside the fingers, considerable improvement may still be secured by the persistent use of physical therapy, of exercises designed to mobilize the affected fingers and of properly designed splints which bring elastic tension to bear on the contracted tendons and stiffened joints. Carefully planned operative procedures, designed to free the fibrosed tendons and nerves from the scar tissue which binds them to one another and to the surrounding tissues and to separate them from underlying bone and covering skin with thin flaps of fat, may be utilized in selected cases. Substitution of new tendons for tendons which have been destroyed and mobilization of ankylosed joints by excision of bone and interposition of thin flaps of fat will bring about a partial restoration of function in those unfortunate cases in which the hand is held immobilized in a vise of scar tissue (Fig. 10).

SUMMARY

Infections of the hand may be divided anatomically into lymphatic infections, localized infections of the subcutaneous tissue spaces, infections of the tendon sheaths, of the fascial spaces of the hand, and of the bones and joints. Of these lymphatic infections and infections of the tendon sheaths and of the fascial spaces are the most important by reason of their frequency and severity. The first should be treated conservatively and operated upon only when there are unequivocal signs of pus formation. Tendon sheath infections and infections of the fascial spaces should be recognized without difficulty for they present definite and unmistakable diagnostic criteria. They should be drained carefully and adequately as soon as the diagnosis is made.

In the post-operative care of hand infections the prevention of secondary infection, early mobilization and the maintenance of the hand in the position of function during the period of enforced immobilization are important details of treatment.

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RHINOLOGY AND INTERNAL MEDICINE*

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No member of the medical brotherhood needs as many professional friends as does the internist, since so many of his general medical problems, many of which at first glance seem very simple, involve other and more special problems which require for satisfactory diagnosis or treatment the aid of one or more specialists. A simple headache may in part belong in the sphere of one of three or four specialists; a simple backache, in one of a still larger number. A specialist is truly a specialist, however, by virtue of his special experience and his specialized technic in the diagnosis and therapy of troubles limited to a narrow field. The evaluation of the findings of the specialist, however, when the problem is but a small part of a more general one, that is, in terms of the patient as a whole, belongs to the internist. These two should work out together the problem of the patient. Nevertheless, in a doubtful case it is the latter who must determine, in general, what is to be done and when; but not how it is to be done. For illustration, the tonsils of three persons may look much alike. To the one patient they have as yet done no harm; the second may, thanks to them, have developed a slight hypertrophic arthritis; but the third patient owes to them a devastating atrophic osteo-arthropathy. That such similar tonsils can affect these three persons in such different

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degrees and manners depends chiefly on the different susceptibility of these three persons to one and the same infection. In like manner the same error of refraction in two persons may explain for the one slight headaches, and drive the second, a more unstable person, almost insane. The satisfactory treatment of all such cases will depend largely on the willingness of consultant and internist to study their patient together.

Perhaps in no field does the internist find as many opportunities for differences of opinion and for serious misunderstandings with a specialist as in rhinology. But it is also possibly true that in no one specialty do the experts differ among themselves in their opinions quite as much as do the rhinologists. We wish at this point, however, to express our hearty appreciation for the friendly cooperation we have invariably received from the many rhinologists of Indiana, who have so thoroughly studied our cases over with us, have so patiently listened to our suggestions, and have so skillfully helped us in the solution of our problems.

This paper, naturally, is not to be a general discussion of rhinology as it appears to the internist. We shall touch on but a few problems, choosing not the important ones, but those which have most often aroused discussion. The cases we shall mention may constitute possibly but a small fraction of the clientele of the rhinologist, but they include those cases which worry the internist, and whose nasal lesions are not convincingly important to the specialist.

By way of introduction, we would emphasize our opinion, not at all original, that the functions of the nose are very important in man's mental, emotional and physical life. In comparison with those of our eyes and ears the contributions of the nose to our mental life may seem insignificant, but this may be because they do not stand out as clearly in consciousness as do those of these other special senses. Vividness in consciousness and importance in the determination of affective emotional attitudes, however, need not be variables with like signs; and while we would not, because of our own ignorance, agree with one eminent specialist who declared that our nose is our *most* important organ of special sense, yet it is the oldest sense phylogenetically, and ontogenetically is the most fundamental. Its sensations are pleasant or unpleasant to a more marked and universal degree than are those of vision or hearing, and so approach in this respect rather the purely sensual characteristics of the lower senses, the bodily appetites. Smell is the most delicate of senses and its associations in our mental life, as judged by experience and as indicated anatomically in the brain, are the widest of all senses. For these reasons we insist that smell plays no small part in the structure of that very important though undefined emotional background, against which the findings of the other senses stand out in such clear relief.

Second, there certainly is no anatomical or physiological evidence that the nose is a vestigial organ. While the sense of smell is not nearly of as much practical daily use to man as it is to some of the lower animals, yet there is no evidence that in man it is a sense which has atrophied from disuse. It gives no evidence of a recessive history. Analogies from the animal kingdom, from the reptiles up, are interesting but often are misleading. Man is not a reptile, neither is he a bloodhound. In man the olfactory nerve is the first cranial nerve when numbered according to its anatomical relation to the highest nerve centers of the brain. It is no accident that the olfactory bulbs are, strictly speaking, not nerves but true outgrowths from the brain. Anatomically these bulbs and the olfactory nerves which branch from them give every evidence of belonging, not to a dim distant past in the animal kingdom, but to man's present. The fact that we know so little that is accurate about an organ gives us no license either to assert that there is little to be known, or to imagine more than the evidence justifies. There is much about the nose, however, which warns us of its great importance and this should lead us to treat it medically and surgically with more respect than as a rule it now is wont to receive.

Third, we would emphasize by way of preface that, among the functions of the nose, smell is by no means the most important. It has other functions in the fields of respiration and sex life which also are fundamental. The nose is a complete organ but with important nerve connections with these two systems. Normally, the effect of these connections may not be vivid in consciousness, but in pathological cases where such are magnified its importance cannot be questioned. The air entering the nose turns at least one complete circle before it reaches the nasopharynx, and while doing this it comes in contact with so many moist mucous substances that very little dust or bacteria ever pass the vocal chords. During this journey the nose prepares the air for the lungs by warming it to the right temperature and by moistening it to the proper degree. It is the tortuous nasal passages, also, which offer just the right resistance to the current of air which inspiration aspirates into the lungs and to that which expiration expels. How important this is becomes only too evident when we study the misshapen chests, mouths, and noses of children who, during the period of their rapid growth, were mouth-breathers.

Since just at present infections would seem to be a very popular subject, we will begin our discussion at that point. All agree that the nose, including its accessory sinuses, is very frequently the seat of pyogenic infection; all will agree that

the amount of pus which daily can be discharged from the nose is vastly greater than tonsils, teeth, or even a bad appendix can produce. There is no question but that the nose is a well-known source of systemic infection through the blood and lymph streams. And all agree that the nasal pus which is swallowed has a very definite effect on the gastrointestinal canal. We internists, however, believe that the power of the nose with its cavities to infect the body is not at all in proportion to the amount of freely flowing pus it produces; in fact, that acute and chronic suppurative sinusitis is, in general, an infection of relatively slight importance so far as systemic infection is concerned. We believe, rather, that there is far more danger from an infected nose the walls of whose sinuses have become transformed into thick pyogenic membranes which produce little or no free exudate, but which have an immense power of germ cultivation, of toxin elaboration, and of toxin absorption. Some of these cases may be later stages of suppurative sinusitis, but many would seem to have been from the first a distinct form, the chronic hyperplastic variety, which often dates to childhood. Such sinuses may for days give no secretion at all; transillumination often gives negative results; the x-ray plates are not always conclusive; and direct inspection may be deceptive since these sinuses open into nasal passages which may appear almost normal. On this point, however, internist and rhinologist often disagree. The latter desires to see evidence of definite pathology before he condemns a nose, and the more pathology he sees the better satisfied he is; but not so the internist. The latter has learned to fear infections in noses which look clear. During the last fifteen years it has been one of our pleasures to lecture to the medical students on the history of medicine, and in these, of course, the question of "laudable pus" receives frequent mention. Since the time of Lister our surgeons have developed a stereotyped habit of mentioning "laudable pus" always with a laugh or a sneer, both of which are hardly justified. Before the days of aseptic surgery the man with a deep infected wound from which pus flowed freely may have had many inconveniences and dangers from this pyogenic infection, but he certainly had a much better immediate chance for life than the man with a somewhat cleaner wound, one which healed promptly by first intention, but who, a few days later, developed tetanus. Of course pent-up pus is always an evil; "laudable" pus always flows freely. Even today free pus has its place. We know only too well that the battle against infection is fought, not on the surface of the infected tissue, but within the tissue spaces themselves; not in the lumen of an abscess cavity, but in its wall. Our irrigations with antiseptic solutions merely wash off from the surface of an infected tissue those germs which can do but little more harm. Blood disinfectants have been disappointing, and are of value only as they aid in encouraging an exudate of leucocytes and blood serum into the advancing edge of the infection. A purulent exudate is our best mechanism of defense for killing and for washing out the germs, and for neutralizing their toxins. That is why a nose with every sinus pouring out pus interests the rhinologist more than the internist; also, why some almost normally appearing noses seem to the internist to be dangerous.

Again, the internist believes that it is infection of the posterior ethmoidal and sphenoidal sinuses which do the patients the most harm, and these the rhinologist finds hardest to examine and the ones whose infections are most often overlooked. These sinuses drain directly into the mediastinum, producing there a mediastinal adenitis and peribronchial infection which cause, and keep alive, practically all of chronic bronchitis and bronchiectasis, which explains most of our latent bronchopneumonias, and perhaps all of our hilum pneumonias, and which initiate the flaring up of many a case of previously arrested tuberculosis. In addition, it is this form of sinusitis which often causes chronic infectious arthritis, and other chronic infections. With such a list as this to their credit the infections of the posterior sinuses are to the internist among the most dangerous foci of infections of the whole body, are those on which depends to no small degree those other infections which shorten the life and reduce the efficiency of the adult man. And yet in such a case the nose may, on direct inspection, look fairly normal, on transillumination there may be no shadow, and the x-ray plates taken of it may be ambiguous. This doctrine had, however, in the past led to a riot of operating on the posterior sinuses, and this has been followed by perhaps too great conservatism. The point we would urge is that, granting that there is any infection at all in these sinuses, the question of operation should not be decided on the basis of the local nasal conditions but on the condition of the patient as a whole, and that the deciding vote for operation must often be cast by the internist.

On what evidence then shall such a decision rest? First, the general condition of the patient must be such that it requires as explanation some continuous focus of infection somewhere in the body. The seriousness of the general condition of the patient will, in large degree, determine what chances we are to take in the way of local operations. As an extreme illustration allow us to cite streptococcus viridans infection, which causes subacute bacterial endocarditis, a condition usually considered to have an almost hopeless prognosis. But why is it so serious? There is little in the clinical picture, except the prognosis, which suggests any great degree of toxicity of the infecting germ, rather the contrary; the germ is counted as one of little virulence. To say that the

development of immunity against this organism is poor is no answer, since the only evidence in favor of this statement is the seriousness of the infection, and that is what we are trying to explain. Clinically, the one most marked feature of these cases is the apparent mildness of this infection, the silence of its systemic processes. Then, is it not natural that its foci of dissemination also should be silent? A few of our cases are now well after three or more years. Why? Because we assumed that its focal infections were silent, and succeeded in persuading the surgeon to operate in fields which gave him only the slenderest evidence that there was any trouble there at all. Evidence of course there must be, but the internist, not the specialist, should determine whether or not such slender local evidence justifies serious operations.

Second, the history of the case should suggest also that sinusitis probably is present, even though the appearance of the nasal passages suggests but little. The many cases of sinusitis which followed the great influenza epidemic are much to the point as illustrations of this. We are very partial to the suggestion of a keen rhinologist that influenza is in fact, and might well be named, epidemic sinusitis. That is, that influenza is an infection caused by a germ which has a particular affinity for the mucosa of the nasal sinuses, much as epidemic meningitis is due to a germ which first invades the whole body but which has a particular affinity for the meninges. After an attack of influenza with general nasal involvement it would seem that the infection of the nasal passages clears up promptly, while that of the sinuses may continue. This is important. Sinusitis is, as a rule, due, directly or indirectly, to lesions in the nasal passages—a deflected septum, a spur, an hypertrophy, etc.—which hinders free nasal drainage, and the very presence of which would suggest that the sinus behind this visible lesion probably is involved. Epidemic influenza, however, after the initial rhinitis had subsided, would seem to have left the sinuses infected, while the visible areas of the nose look relatively normal. We have the same problem also in many cases of antrum infection which started from alveolar abscesses. Here the nose may give no clue of the infection, nor transillumination, nor x-ray films. Over such cases rhinologist and internist often cross swords. We remind them of a hotel corridor, clear, clean, and quiet; but who knows what mischief is going on in the rooms which open onto that corridor but with doors now closed?

Third, while the history of several grippe-like attacks, of frequent colds in the head, of nasal catarrh, etc., may not prove the existence of a sinusitis, they certainly suggest that this should be excluded. The patient says "he catches cold easily." As a matter of fact, he does not catch cold easily, but has the same cold all the time. For months this is quiet, then it flares up, later to subside. Such may be caused by a visible nasal lesion, by bad tonsils, or by infected tracheobronchial lymph nodes, but very often by an infected sinus. Especially is this likely to be the case if, after a period of comparatively good health, a "cold in the head" develops rapidly (in less than one day), and with, from the first, a purulent secretion. Acute rhinitis, even if aided by a spur or other local area of pressure, must have its period of incubation and that of prodromal symptoms with water mucoid discharge. In sinus cases these fail.

Fourth, to the internist there is no such clinical entity as "catarrh" or "catarrhal inflammations." In the case of the nose a catarrh is only "smoke" spreading from a small smudge flame, *i. e.,* a latent infection, which lurks somewhere in the nose or in its cavities. Treat this catarrh, that is, give the nose general treatment, and you get nowhere; eliminate that one small point, and all clears up.

Fifth, the examination of the nose should be made at the time when evidences of the trouble are most likely to be visible. That is, during an acute exacerbation of the trouble, and not between flare-ups.

Sixth, the x-ray picture of mediastinal adenitis gives, in our experience, fairly accurate evidence of posterior sinusitis, even in the absence in the nose of visible evidences of that condition.

The diagnosis of sinus trouble should not rest on any one or two of these points, but if several coexist the evidence is in its favor whatever may be the appearance of the nasal passages.

The medical man for centuries has interested himself in those reflexes of the nose which operate in two great systems: the lungs and the pelvis. Few subjects are more tantalizing. Few fields can be, or have been, so exploited by quack and charlatan. The natural result is that the little ten percent of truth concerning them is buried in the disgrace of the ninety percent of unwarranted speculation concerning them, which last year so aroused the ire of Professor Shambaugh. It is this ten percent with which the internist must reckon. This discussion, however, should receive a few prefatory remarks.

First, the disturbances in the spheres we are now to discuss are largely physiological, only slightly anatomical. In fact, the more marked the anatomical lesion the less chance is there that these troubles can arise. The nose must, therefore, be tested rather than merely inspected.

Second, only a fairly normal nose can develop a pathological or an exaggerated reflex. There must, of course, be some lesion, but only enough to exaggerate, and not enough to destroy the normal nervous or secreting functions of the nasal tissues. The more definite is the disease of the nose, as observed objectively, the less chance there is that these reflexes are present. For this reason,

when the rhinologist is most willing to operate on a nose, we are least interested; and when we are most interested is when he is most skeptical. Again, the rhinologist and the internist do not see the patient at the same time of day. The rhinologist has definite office hours, those most convenient to himself, and they are seldom in the early morning. It is during those hours that he expects the patient to come and to await his or her turn. For the recognition of the nasal troubles we are now considering the result is naturally disappointing. Nasal disturbances are usually morning phenomena. Suppose that the detective department, on receiving word of a crime, were to delay investigations until late afternoon, and then were to begin by cleaning up all signs of blood stains and by removing all weapons and broken furniture. What could they find? Yet this is essentially what the rhinologist does. The noses we are now considering look more normal in the afternoon than in the morning, and a preliminary spray with adrenalin and any of the cocaine-like bodies will remove much of the evidence of that which we believe is causing symptoms.

Certain morning headaches, not those which deserve the term of migraine, and not every morning headache, will serve as a good illustration of these problems. Nasal pressure headaches may even awaken the patient in the late morning hours, but at least will be present at his usual hour of waking. History will show that he had none on retiring the night before. They are dull in character, apparently deep seated, are not very throbbing; they are practically always bilateral, and are most marked in the frontal and occipital regions. What is more important, they are accompanied by a mental depression which is almost pathognomonic when well described. As in certain of the eye strain cases, the element of physical pain may be insignificant, even absent, and as a result some of the nasal pressure syndromes have been called "painless headache," "headache equivalents," etc., and a few of them may pass as primary psychic depression. The public call the effects of this morning headache the "morning grouch." The patient is apt to describe his feelings as a "fog on the mind," "cobwebs on the brain," etc.; the problems of the day "loom up big"; "seem perhaps unsurmountable"; in a well-marked case "life is not worth living." While we would never be guilty of saying that a nose condition could lead to suicide, yet we have no doubt that one reason why a large number of suicides occur between six and nine o'clock in the morning is that so many truly mentally depressed persons have also noses which add to their depression. The average man, however, gets up, shakes himself a bit, takes a cold sponge, a few deep breaths, then a strong cup of coffee with bacon and eggs, and by nine o'clock is ready for the day's work and is happy. These headaches, in nine-tenths of the cases, are pressure headaches, and arise from areas of the nasal mucosa where the erectile tissue is capable of considerable turgescence. Such a nose in the afternoon may, on inspection, give little evidence of infection, since there need be no infection there; and the slight deflection of the septum or the slight hypertrophy present will seem unimportant, because then there actually is free breathing space through the narrowed nostril. Had this nose been inspected earlier in the day, however, the appearance might have been quite different.

That nasal conditions are important in the causation of hay fever none will deny. That hay fever is, in large degree, merely an exaggeration of the functioning of a normal mechanism of the nose intended to protect the lung, we believe; that this hypersensitiveness may be an inheritable characteristic, I believe you all will grant; that in persons without idiopathic hay fever a relatively slight nasal pathology can so increase the normal sensitiveness of the nose, or of the slightly hypersensitive nose, that hay fever results, we feel is true beyond dispute. That there is justification for the theories that hay fever is evidence of sensitiveness of the individual to proteids ingested by the gastrointestinal canal, we doubt; and that there is any sense in the use of the term "anaphylatic shock" as applied to these cases is, we think, emphatically to be denied. That it is foolish to talk of curing the inherited, that is, the idiopathic, form of hay fever other than by lowering the sensitiveness of the nose by inoculations, we feel is true; but that we can, by proper local operation, lower that hypersensitiveness if it is due to a nasal lesion is, we think, proven. Those cases in which the first asthma attack came in middle life or later should not be encouraged to trust vaccine treatment, excepting as a purely palliative measure, secondary to good surgical treatment of the local lesions which may have rendered the nose so susceptible.

The problem of asthma with or without hay fever is a difficult problem to discuss. That, in the child, asthma sometimes is due to a nasal reflexes may be granted, but that the same is true of the adult may be open to doubt. In the child the problem is relatively simple, for if we remove the adenoid or the polyp, the attacks of asthma will decrease in number. This is granted, although the child may remain as definitely "spasmophilic" (to use the term of the pediatrician) as before; but "spasmophilic" some are born and "spasmophilic" these will die. Asthma of the child is in large measure an exaggeration of a normal condition, and in many cases is due to a local, often trivial, nasal lesion. Protect this mechanism by fairly conservative nasal treatment and at least we reduce the tendency to asthmatic attacks. In the adult, however, instead of one exciting lesion in the nose there may be several. In adults with bronchial asthma we find chronic hyperplastic ethmoiditis, large polypi filling the meatuses, and

infected lymph glands along the trachea and at its bifurcation, all of which may play some part in explaining the persistence of those conditions which makes spasmodic asthma possible; and these, nasal treatments alone do not remove.

The relation of the nose to the genital life is a difficult one, not so much because the evidence is lacking, for clinical evidence of certain sorts is over-abundant, but because of the difficulty of overcoming the bashfulness of the patient and of eliminating suggestion. Of the special senses smell is most closely connected with the bodily appetites, and over-indulgence of this one sense has, historically, "been associated frequently with periods of marked decadence of virtue among civilized nations." This relationship is important and must have considerable value in internal medicine, but what is it? How are we to judge it? Granted that our patients desire to be frank, they cannot evaluate the subliminal nor disentangle the conscious from their fears or their obsessions. We have had as patients men who were so disturbed and humiliated by certain urges and drives of their lower nature, quite at variance with their spiritual ambitions, that they made this a matter of consultation; also more who referred to these symptoms casually in the story of their case. These men state that they were much relieved as a result of the correction of relatively simple nasal hypertrophies. The number of women patients who have unconsciously shown such relationship is much greater. In these cases there is, fortunately for them, no conscious sex element present. They complain of dysmenorrhea. While we would not agree with the claim of enthusiasts that dysmenorrhea is more often cured by nasal treatment than by pelvic operation, yet some cases are. Of course, definition is important. By dysmenorrhea we do not mean profuse or scanty menstruation; the amount of the flow would seem to be determined by other factors. Neither do we have reference to the regularity or irregularity of the periods; this also is controlled elsewhere. Neither do we refer to that painful menstruation which is described in terms of colic and which is accompanied by the passage of clots in the flow; that has other causes. We do refer, however, to certain general, nervous, irritable, disagreeable sensations of which some women complain, which increase as the period progresses, and which sometimes are relieved promptly by conservative nasal treatments. It is in the study of these cases especially that the open-minded rhinologist, the careful internist, and the real gynecologist can demonstrate the value of frank consultation.

SOME PHASES OF ULCERATIVE COLITIS*

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Within the past few years we have been confronted with an ever increasing number of patients suffering with colitis, either of the benign group with indefinite symptoms referred to the bowel, or the pernicious type with bloody diarrhœa and marked impairment of efficiency. In my experience colonic diseases are more prevalent in cities than in rural communities. There are several logical reasons for this increasing incidence, probably the most important of which is the fact that we have been, and to a large extent still are, unable to cope satisfactorily with it. We have treated our old patients for years and have added new ones, so that in time we have accumulated goodly sized groups. A second and also important reason is that within recent years the dietary of the average individual has been greatly modified from what it was twenty years ago. A third factor is that radical steps in treatment are not instituted early enough in the disease.

Many people go through life eating normally, taking care of their food, and never developing a consciousness that beyond their mouths lies a delicately constructed, highly sensitive gastro-intestinal tract, and it is worth while to consider them, and why they are normal. A normal individual is born right. He comes of sound stock that lived hard, reared families, developed no social complexes and worked out their lives. He inherits a constitutional stamina and a series of physical attributes which his less fortunate fellows lack. From a viewpoint of gastro-enterology he is blessed with five characteristics:

First, an anatomically normal body; he is not too broad and not too lean; his general conformation and posture are average, and there are no kinks, strictures, dilatations, adhesions or malpositions to interfere with functional activity.

Second, he has a normal food tolerance; the starches which he eats are hydrolyzed into sugars by efficient amylopsin; proteins are converted into their amino-acids by efficient pepsin, trypsin and enterokinase, and fats are emulsified in a proper period of time. The foods which he eats are digested and the nutritious end products are absorbed.

Third, he inherits an endocrine balance, in that the end results of the activity of the thyroid, pituitary, adrenals, pancreas and other organs of internal secretion, balancing and offsetting each other, is the maintenance of a stable physiological unit, a machine which retains its muscular tone, adjusts itself and responds normally to stimulation.

Fourth, and closely related to the endocrine system, he inherits a balanced and properly toned

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sympathetic and para-sympathetic nervous system. No foci are present to stimulate either unduly. Motility and secretion and sphincter control are not grossly excited by vagotonia or depressed by sympatheticatonia.

Fifth, the normal individual is endowed with an absorptive mechanism which cares for the food end products after they have undergone hydrolytic cleavage and are delivered to the bowel portals of entry in soluble form. This concerns almost entirely the small intestines from lower duodenum to lower ilium and is usually the last function to be impaired in bowel pathology. Practically no absorption takes place from the stomach and practically none, except water, from the colon.

Heritage is thus the prime prerequisite for health, but the factor of living and keeping a heritage is of little less importance in modern times. I believe that one of the greatest health problems which confronts us in the coming era of preventative medicine is that of fatigue. We see it first in the fussy, hyper-irritable, hyper-sensitive child whose mother unwisely drags it to the picture show when it should be asleep; shows it off to friends; encourages precocity, trains it and disturbs it until at the age of four we have a frail, timid child with a well-developed case of nerve exhaustion, with vagatonia and spastic constipation; and last is the tired business man who slaves in a stuffy office all day, tosses sleepless until the small hours of the morning and awakens too late for his breakfast. With exhaustion, whether physical or nervous, the gastro-intestinal trace is likely to be the first to become deranged.

Next to fatigue comes the question of food and eating habits. The great percentage of bowel patients, in explaining their history, states that their diet consists of fruit, vegetables, bran and milk. Highly paid advertising experts have been retained to teach the United States that these foods contain a panacea to all the ills that flesh is heir to, and we have placed the iron of raisins, the bulk of bran and the vitamins of vegetables at the top of the diet list for the generally unfit. Are we not over-emphasizing these factors? The human body is built of proteins, daily loses protein and requires this food for the maintenance of its nitrogen equilibrium. As much as we have read concerning protein putrefaction and its harmful effect, it is the rarest individual who shows indol or indican in stool or urine unless the bowel condition is acute; it is the rarest patient who develops high blood pressure from eating meat unless there is definite kidney pathology. The sufferer from chronic colitis is apt to carry unhealthy fat, as evidence that he does not need more carbohydrates; and is apt to be tired and weak, with excessively low blood pressure, atonic muscles and visceroptosis, as evidence that there is nitrogen depletion in the tissues. Many who consult us suffering from colonic disturbances have eaten no meat in weeks or months previously. We should not have much confidence in the newer, cheaper, refined, pre-digested foods, but know that a sound, balanced diet of meat daily, starches conservatively, fruit sparingly, along with regularity of meals three times a day will conserve vitality and maintain health more often than these other foods.

We are now ready to depart from the normal individual and consider the pathological bowel case. In considering colonic irritation as a departure from the normal, an organism goes through a series of steps which I will attempt to outline. This is no hard and fast rule and would not apply to all cases, but I believe that as a generality it approaches the truth. Probably the first predisposing cause of a colitis is a generally lowered vitality and resistance. Due to a variety of causes the patient becomes below par. This may be due, as I have suggested, to hereditary weakness. It may be the result of contagious disease; not infrequently a low grade respiratory infection may set up bowel hyper-irritability which we call intestinal "flu"; immoderation in food may starve the body of essential food elements or cause irritative symptoms by their physical nature; exhaustion from over-work, over-play or lack of sleep. Any or all of these elements may enter in as causative factors of lowered vitality.

The next important step in the development of a colitis is an increased intestinal rate and this symptom persists throughout the course of most colonic disturbances. With lowered vitality comes lowered efficiency of the digestive enzymes and ensuing lack of digestion. Even though normal amounts of starch are ingested, the tolerance of the patient for it is impaired and unhydrolized starch, usually encased in cellulose, is carried into the colon, where acid fermentation occurs with irritation of the bowel mucosa. At this point, also, when the starch tolerance has been broken and the bowel has become acid in reaction, the patient not infrequently goes on a diet with even more starchy foods and omits the proteins entirely. Following the escape of starch into the large intestine the stool becomes acid, flatulence develops, belching, slightly colicy pains and tenesmus, the mouth tastes metallic, the tongue is coated, and the patient often realizes that his whole system is hyperacid. Fruit juices are taken for their systemic alkalinizing effect. Orange juice is composed of a fruit acid and an alkaline ash. In cases of true acidosis, or faulty oxidation of fats, such as seen in diabetes, when the gastro-intestinal tract is not particularly involved, great benefit is derived from orange juice. The fruit acid is readily converted into fruit sugar which is oxidized and the alkaline ash remains to exert its influence in the chemistry of the blood. But this is strictly a tissue reaction, and the presumption is that the orange juice has been absorbed through the bowel and into the blood stream. In acid fermentation of the colon it is easy to conceive that with the bowel

already filled with partly digested starch and organic acids, the orange juice will only add another fruit sugar to ferment and irritate the bowel without being absorbed. I have seen hospital cases, bloated almost beyond tolerance, being fed nothing but orange juice in hopes of lessening their acidity and making their bowels move. Often sufficient irritation occurs to force practically all foods into and through the colon quite undigested. The organic acids and by-products of fermentation which form in the bowel are either absorbed into the blood or neutralized by alkaline secretion into the bowel; in either case the alkaline reserve of the blood becomes impaired. This is not a true acidosis, but rather an unusual expenditure of blood alkalies, to which depletion the blood must adjust itself. We see this expressed in the saliva, which becomes only weakly alkaline; in the stomach, which becomes hyper-acid; in the pancreatic juices, which are of lowered alkalinity, and ultimately in acidification of the entire gastro-intestinal tract, which becomes hyper-motile, hyper-irritable, drawn into irregular spasms and with its normal peristaltic gradient grossly upset.

Another set of conditions which may give rise to hyper-motility of the intestine, aside from broken food tolerance and acid fermentation, are those which cause stimulation of the vagus nerve. The vagus, of course, stimulates motility and secretion of the bowel, and any conditions which stimulate the vagus may give rise to marked intestinal disturbances. Thus we find tuberculosis of the lung, particularly with cavity formation, sending reflex impulses into the abdomen, at one time predominately constricting the circular layer of the bowel musculature, giving rise to spasmotic pains and spastic constipation, at another, and under conditions not clearly understood, contracting the longitudinal fibers with ensuing increased paristalsis and diarrhœa. Early pneumonia may so stimulate the vagus as to create bowel disturbances which may be mistaken for appendicitis. According to Pottinger the close central relationship between the afferent sensory fibers of the fifth nerve with the motor fibers of the vagus permits vagotonia from stimulation of the fifth, in consequence of which we may find eye strain, sinus infection or an abscessed tooth provoking bowel irritability, which may end in colitis.

Hyperthyroidism must also be mentioned as a causative factor for bowel irritability, not due to any nervous mechanism, but rather undue stress upon the bowel by an increased metabolic rate. Several cases of so-called ulcerative colitis have been reported cured by the use of tincture of iodine, and considering its inefficacy in the average case of this sort we are led to wonder if the iodine did not help the thyroid and allow the colon to become healed with its source of irritation removed.

Thus we may consider chest pathology, head pathology and hyperthyroidism among the many predisposing causes of colitis, and in addition the appendix, gall bladder and pelvic organs are so frequently the offenders that no gastro-intestinal study is complete without the elimination of these viscera from the etiological field. These are the extrinsic factors in bowel irritation, and we must add to them the intrinsic influences, or those arising from within the bowel itself to cause disfunction. The unnecessary use of drastic cathartics. the habit of daily laxatives and the constant use of fodder foods which have an irritating residue. or mineral oil, which coats food particles and forms a barrier to digestive enzymes, afford daily insults to the mucous membrane of the bowel and probably render more people unfit than any single disease entity. Intestinal tuberculosis, malignancy, infection with the amœba or dysentery bacillus and typhoid fever are further factors which may affect the bowel itself, but these diseases are organic, usually lead us to early diagnosis or run their course too rapidly to be of clinical importance in causes of inflammatory changes in the bowel.

If we consider lowered vitality as the first step, and increased bowel rate as the second, in the development of colitis, we next come to the third factor, which is failure of assimilation. This is the direct result of hypermotility and is purely mechanical. The cleavage of starch and protein requires at least six hours contact with the digestive juices, in the small intestine, and dehydration of the residue in the neighborhood of twenty hours in the colon and it is not at all unusual in cases of colonic irritation to find food in the stool which has been ingested no more than eight hours previously. This alone renders digestion improbable, and when this has persisted long enough to allow marked fermentation to occur and the enzymes to lose their potency, the likelihood of digestion is rendered even more remote. An average stool examination, drawn from examination of many patients with colitis, is about as follows: The consistency is either soft and unformed or hard small lumps with a watery content, depending upon whether the patient is in the phase of constipation or diarrhœa, or whether or not they have recently taken laxatives or enemata. Watery or unformed movements are acid in reaction, sometimes sufficiently to turn litmus paper, usually only enough to reflect itself in a lowered Ph. Over a long series of examination we ran the hydrogen-ion concentration of soft stools and have now omitted this test because acidity is so constant a finding. Mucus varies in accordance with irritation and nervous influences bearing on the bowel. We are not justified in regarding mucus as direct indication of inflammation, as many cases of mucus colitis, wherein the stimulation of the mucus glands is of purely nervous origin, we find practically no inflammatory changes until

late in the disease. Vegetable fibers are the rule and starch granules are usually found under the microscope. Bile is always present, green if the bowel rate is excessive, brown if oxidation has occurred. Meat fibers are practically never found, partly because these patients have not been eating meat, partly because the protein tolerance is good in such individuals. Our patient starts with lowered vitality from some cause, develops hypermotility of the bowel due to broken food tolerance or any of the other influences mentioned; fails consequently to assimilate his food and becomes further weakened. This process continues in a vicious cycle until the intestinal field is prepared for sewing the seed of any disease.

In considering the subject of ulcerative colitis, from an etiological point of view all the foregoing is of prime importance. The patient who develops ulcerative colitis for years previously has not been normal, he has been unable or uneducated to eat properly, he has been a subject of nervous or physical debility, he has had abnormal bowel reflexes and a deranged alimentary mechanism. Recently Bargen of the Mayo Clinic has isolated an organism which is commonly known as the Diplococcus of Bargen. This is reported to be a gram positive diplococcus, somewhat larger than the pneumococcus, which is cultured fairly well but grows slowly in the ordinary media. He reports that he has found it in approximately ninety percent of ulcerative colitis cases and its vaccine and filtrate are used beneficially in the treatment of this disease. The work of Bargen is of extreme interest as it gives one specific, hopeful, curative measure among the myriads of treatment plans which have been recommended by various authors up to this time. But even in view of this work we must come back to the broader etiological factors to explain the disease. With the colon functioning improperly, with its motility increased, its muscles irregularly contracted, its blood supply impaired; with its mucous membrane continuously bathed in organic acids and by-products of acid fermentation, we wonder if sooner or later the pneumococcus, streptococcus or colon bacillus would not gain entry and become a causative factor for ulcerations. In most cases which run their weary course to an ultimate ulceration of the bowel mucosa, such a past history is found. Paulson, of Baltimore, in a recent article, has reported seventeen cases of acute ulcerative colitis studied from a bacterial point of view with the following findings: Ten distinct types of streptococci were isolated from the ulcers. Seven types were injected into thirty-four rabbits, five of which produced lesions in the animals. Twenty other rabbits were injected with seven types of bacteria from other sources than ulcerative colitis and twelve rabbits showed the same type of lesions as those injected with organisms from the colitis cases, and concludes that the bacterial etiology of ulcerative colitis is still unknown.

Little needs be said of the symptomatology of ulcerative colitis. Constipation may alternate with periods of profuse bloody diarrhœa. During an active phase there may be as many as twenty bowel movements daily. Following a few days of diarrhoea may come remissions of months duration. This remission, however, is never complete recovery; the patient, unless especially treated, will only improve to the level of his chronic bowel state which prevailed before the ulcerative colitis started. There is often very little pain, rarely any fever except with the first attack, and the general condition of the patient is usually good until anæmia or extreme mal-nutrition manifest themselves. Many women who incline to ovarian insufficiency look remarkably well when they are most miserable. Apprehension and worry are real factors until a diagnosis has been made and the patient assured that tuberculosis or cancer are not causing their trouble. Cancer is not such a problem, but it is frequently not so easy to give complete assurance that there is not a low grade tuberculosis exciting reflexes even though not causing the ulceration and bleeding.

Pathology is first developed in the rectum and sigmoid, consisting of, first, an acute inflammation, followed by necrosis and superficial ulceration, which usually penetrates no deeper than the submucous or muscular layer. There is no undermining and the tendency is to spread superficially and heal with very little scar formation. As each ulcer heals, however, there is slight contracting and the eventual picture is that of a thickened bowel wall with even, tubular lumen. Severe cases may lead to perforation, but usually the chronicity of the infection has protected the field with serous exudate and fibrin and a very local peritoneal inflammation follows. Buie, who has written a classical summary of ulcerative colitis, describes four stages: first, a diffuse hyperæmia of rectum; second, infiltration and thickening of the mucous membrane, still inflammatory and easily made to bleed; third, the development of miliary abscesses immediately under the superficial layer of the mucosa and, fourth, the breaking down of the abscesses to leave ulcers. He considers the pin head ulcers of the active stage, associated with pock-like scars of the ulcers which have healed as pathognomonic.

Differential diagnosis of ulcerative colitis involves elimination of infecton with amœba hystolitica. The stool is examined with the high power of the microscope on a slide kept at body temperature by some device and a diagnosis of amœba should depend on finding a motile, irregular, translucent organism, six to ten times larger than a pus cell. It is unsafe to diagnose amœba from finding the encysted form. English authors have reported cases of ulcerative colitis cured with emetine hydrochloride, but possibly these were amœba infections where the organism could not be found.

Typhoid fever may need to be ruled out in

certain cases, but the general condition of the patient and the Widal agglutination test usually simplify this problem. Tuberculosis and actinomycosis are most apt to have inception in the cæcum and ascending colon, while in ulcerative colitis the distal end of the bowel is first involved.

Logan's x-ray picture of this disease depicts a narrowed, irregularly spastic, rapidly emptying, non-haustrated, tubular colon as typical when the disease extends above the rectum, and this finding, accompanied by the sigmoidoscopic findings described above should complete a diagnosis.

Carcinoma and syphilitic lesions are usually seen as filling defects of the bowel with more or less obstruction and proximal dilatation, and a tumor mass is often palpable. Syphilis of the colon is rarely ever seen. Diverticulosis show extra lumenal shadows.

Satisfactory treatment of advanced ulcerative colitis has not been discovered. By all odds the most satisfactory medical procedure is a mixture of Bargen's diplococcus and filtrate given up to the patient's tolerance. Tincture of iodine has been recommended and may act in some way to enhance the value of the vaccine. I have found that a protein diet, a mixture of charcoal, calcium carbonate, and bismuth by mouth, daily bowel flushings with 1/5000 acroflavine in thin starch water and a weak solution of glycerite of tannic acid, along with autogenous vaccines made in bran dextrose broth from the ulcerations have helped cases or thrown them into remissions, but as yet can report no complete recovery. It is important to eradicate foci of infection, such as teeth and tonsils, as the specific organism has been cultured from these places by report, but elimination of the foci will not cure advanced cases as there is secondary infection not related to the primary cause.

My thought in this paper is to urge that diseases or constitutional factors, intrinsic or extrinsic to the colon, which reflect themselves in bowel irritation be diagnosed and treated before ulcerative colitis occurs. Any patient who has been suffering from a low grade bowel disturbance, who has become habitually constipated, undernourished and sick may be regarded as a potential case of ulcerative colitis, and we are justified in doing tedious, time-consuming work to determine his trouble before specific ulceration occurs.

In summary: The specific diplococcus or streptococcus which causes ulcerative colitis affects individuals who have a background of previous colonic disturbance. The prodromal symptoms are fatigue, increased bowel rate from improper eating, broken carbohydrate tolerance, acid fermentation, and lack of assimilation; endocrine unbalance, especially hyperthyroidism or stimulation of the vagus nerve from causes within the bowel or elsewhere in the body. We are justified in stressing these less pronounced symptoms and correcting their cause before ulcerative colitis develops.

FULL-TERM EXTRA-UTERINE PREGNANCY

(Report of a Case)

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PERU

Extra-uterine pregnancies are by no means rare and in more recent years we find the occurrence ever increasing. This is undoubtedly due to the fact that in the last two decades cases have been diagnosed more accurately. It is impossible to give the incidence exactly, but they probably represent in the neighborhood of .003 percent of the total number of pregnancies. Still further, the vast majority are ectopic and terminate relatively early. There have been very few abdominal pregnancies reported, and we have been unable to find any which have gone to full term and concluded with a live mother and child. Lane has reported one in which the child was found free in the peritoneal cavity and lived for twenty-four hours. The history of the case is as follows:

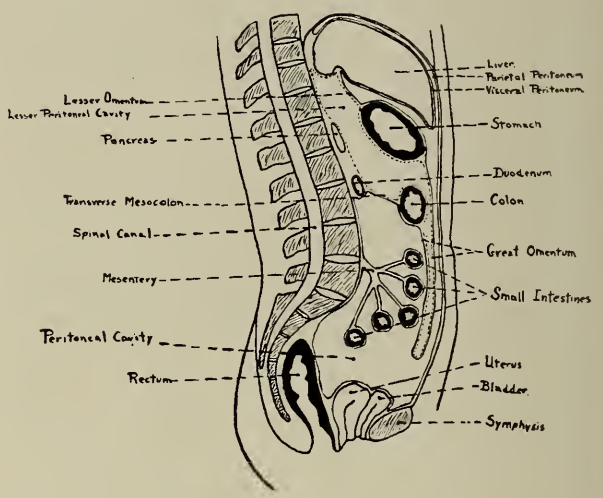


Fig. 1.

Mrs. K. G., Peru, Indiana, thirty years old. No previous pregnancies. Married six years, five months. Previous health excellent. Menses began at about sixteen years; irregular at first, but very regular for past ten years; twenty-eight-day type; four to five days duration; moderately painful; last period some time between the 5th and 18th of February, 1927. On March 28 she had a bad cold and went to her doctor telling him that she had missed her period. He was unable to find any evidence of pregnancy. April 21 she was taken suddenly ill with severe pain in the abdomen radiating into both flanks. It was so bad that she had to go to bed. This lasted for about three days, after which she was able to get up and sit in a chair, but a few days later the pain recurred and she was forced to go to bed again. She said that from that time on she was never entirely free from this pain which she could not localize any more definitely than that it was in the lower abdomen and flanks. About July she had not felt life, and although

the menses were still absent, she was not convinced that she was pregnant. Her abdomen was enlarging, but her doctor told her that her womb was normal in size. She had also had no nausea. The diagnosis given her at this time was that she either had a tumor or a tubal pregnancy. About August 1 she changed doctors, and it was about one week previous to this that she felt some sensation in her abdomen which she now believes were the first fœtal movements. Examination at this time conclusively confirmed the pregnancy, as the fœtal heart tones were easily heard to the left and above the umbilicus. A bi-manual examination was not made. On September 9, 1927, the abdominal pain again became so intense that she had to go to bed. She said that from this time "I was in and out of bed so often that I cannot recall just how it was."

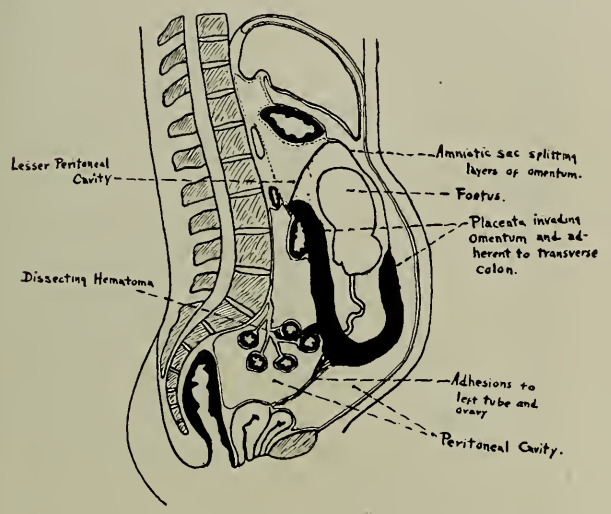


Fig. 2.

She did notice that while previously the abdomen had been steadily enlarging, it now seemed to increase in size more rapidly. November 13 the pain became even more severe than ever before. Although continually unbearable, it was excruciating whenever the baby moved. The following day she knew she was worse, but could not explain why. She was brought to the hospital, prepared for surgery, and given a preliminary hypodermic of one-fourth grain morphine. Incidentally this was her birthday. Operation began at twelve noon. Ether anesthesia was administered. A midline incision was made from one and a half inches above the umbilicus to about the same distance above the symphysis. Immediately upon opening the peritoneum a large dark, vascular mass presented itself. The incision was found to be too low to permit delivery, so it was extended above. This instantly revealed the body of the child lying beneath the omentum and transversely in the abdomen with the head to the left. The overlying omentum was very thin, and as it extended downward it merged gradually into the vascular mass which was the placenta. An opening was made through the omentum, with the escape of a small amount of amniotic fluid. The baby was removed through the opening, the cord clamped and severed. Some difficulty was encountered in getting the child to breathe, and this was attributed to the ether and the preliminary hypodermic. The placenta was then removed, which proved to be a tedious and difficult procedure, so intimately was it associated with the omentum, transverse colon and mesocolon. Almost all of the omentum had been invaded by the placenta, and with the removal of this only a very small portion remained. There was a dense mass of adhesions found connecting the left tube and ovary and the placenta. On the other side a tremendous hematoma was found burrowing down from the placenta into the mesentery of the cœcum and ascending colon and extending posteriorly to the parietal peritoneum beneath these structures. The accompanying diagrams perhaps show the relationship better than can be expressed in writing. After removing the blood clot from the hematoma, the sac which it had formed was obliterated by sewing the walls together with catgut. The amniotic sac had split the layers of the omentum, invading the lesser peritoneal cavity, and these were reapposed by sutures. The uterus was normal in size and position, as were also the right tube and ovary. A large gauze pack was placed in the region of the hematoma, where there was some tendency to ooze, and brought out through the incision to act also as a drain and a split rubber tube was incorporated around it. The operation closed at 1:10 p. m. The immediate post-operative condition was good. The baby weighed seven pounds ten ounces and was a girl. Recovery was uneventful. The patient was transferred by ambulance to her home on the sixth post-operative day. Drainage consisted of serosanguinous material and at the present writing (forty-three days since the delivery) has almost completely subsided, and the patient is able to care for herself and part of her household work. The temperature was never above 102 nor the pulse above 120.

The pre-operative diagnosis (and the indication for the Cæsarian) was transverse presentation.

DIPHTHERIA PREVENTION WORK*

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and
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The reading of 6,437 Schick tests given to pupils and teachers in the Gary schools has shown that 3,335, or fifty-two percent, appear to be immune to diphtheria toxin in ordinary doses. This, we think, means that they would not be made ill by any usual dosage of diphtheria toxin and that

*Presented before meeting of the Lake County Medical Society, January 12, 1928.

there would be no danger from any usual diphtheria infections. These persons may become diphtheria carriers, however.

We have found 3,102 persons, or forty-eight percent, Schick positive (Table No. 1), which is thought to mean that they are susceptible and might be made ill with virulent diphtheria germs. These we have attempted to immunize with diphtheria toxin-antitoxin. We have given most of these the usual three doses of diphtheria toxin-antitoxin.

The Schick test material and also the T. A. has been bought in the market and products have come from four different biological manufacturers. For the past two years they have been furnished by the City Health Department. Several hundred tests were given with New York City Health Department material in 1924-25.

One thousand six hundred sixty-eight have been retested three months to one year after the last dose of T. A. with the finding that 1,170, or seventy percent, are Schick negative (Table No. II), which we hope indicates immunity to diphtheria. Those who were positive on retest have been advised to take three more doses. The second series has usually brought about a negative Schick test.

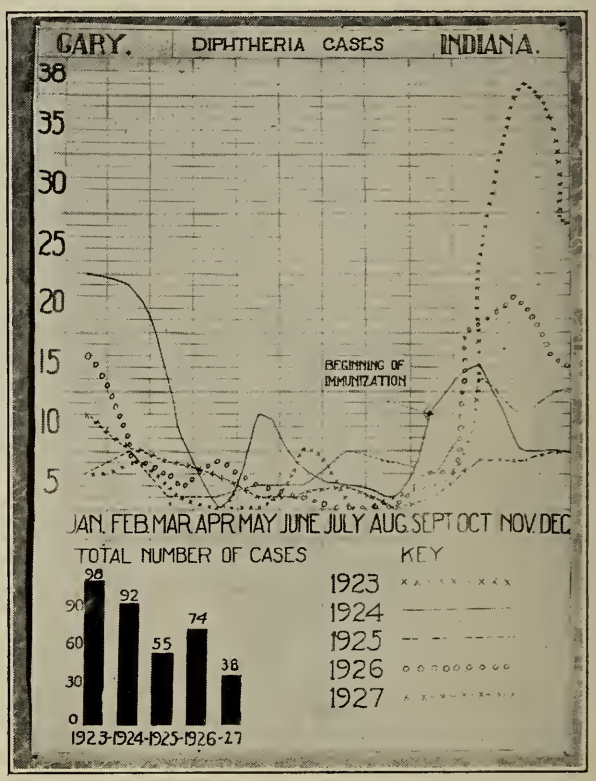
One disadvantage that we encounter is with the Schick test material as well as the toxin-antitoxin, for the reason that they are subject to deterioration from heat, age and other causes. We have given tests to large groups and have found when we began to read them that the test material was "off." This has occurred in three instances here and once at the Dallas meeting of the A. M. A. when a good manufacturer sent some test material to be used in advance of the meeting. When the children arrived for reading and to assist us with the demonstration, they were all negative. When the tests were given again with other material, most of them were positive, as they should have been. Poor material cannot be detected as easily in individual tests as in group work, and in our opinion, an individual test without the testing of the material is of little value.

The opinion of the leaders in public health work is that the family physician had better disregard the initial Schick test, give the toxin-antitoxin (three doses may be given, or, if he is very anxious to be sure to immunize his patient, give five doses) from five to seven days intervening between doses, and give a Schick test to a group or have the test given by someone giving group tests, six months later. Those Schick positive should have additional T. A.

The pre-school age children need to be immunized. It can be started any time after the sixth month. These children can be immunized by the family physician with some financial benefit to himself and much good to the families he serves and the community.

Do not promise these people immunity for from three to six months after the doses are given, and be sure to tell them that only a Schick test can tell whether they are immune or not. Remember that some of those Schick negative may become diphtheria carriers without symptoms beyond coryza, slight sore throat, etc. Do not be surprised when one of them develops a diphtheria, which you should properly diagnose and treat with diphtheria antitoxin.

Schick tests should be given with a control of heated toxin. No constitutional disturbance should follow. If an excess of toxin is used in the mixture a blister may form which will break down, but which heals rapidly.



The incidence of diphtheria in Gary since immunization was begun has lessened as shown by fewer cases being reported by doctors, the finding of fewer positive cultures at the laboratory, and also by fewer deaths. The percent of cases dying, of those reported, is still very high (Table No. III). This is due, of course, to the doctor not being called early enough, or his failure to use antitoxin immediately.

The general public are not normally carriers of diphtheria and scarlet fever. The carriers usually are found in a class at school where diphtheria has existed in mild form and several cases have occurred before the conditions are recognized. When these diseases become epidemic in an institution or in a school or a community, many carriers may be found.

If the health officers could require that all institutions operated and maintained for the care of children, such as orphan asylums, boarding schools, and children's homes, should have all the

personnel and inmates immunized against diphtheria, scarlet fever, and smallpox, and kept so, it would lessen the incidence of these diseases and decrease the mortality, besides proving a good money-saving undertaking. The reactions from T. A. are at times rather severe, but have never been serious and are preferable to the treacherous disease. Because a child has had a dose of T. A. and may have some reaction does not prevent it from developing diphtheria or anything else immediately after, and should not relieve the physician in using ordinary care, skill, and diligence in making a diagnosis.

Reactions occurring after 2,055 doses of T. A. in three of our larger schools caused fourteen pupils to offer it as a cause for losing thirteen days. Three cases of diphtheria with fifteen other school children in their families caused them to lose 319 days from school. Two hundred eleven nose and throat swabs from pupils in these schools were all negative. Gary has enough persons susceptible to diphtheria for an infected milk supply, through an accident to the machinery or careless operation in some pasteurizing plant, to set up the worst epidemic we ever have had, so continued zeal should be exercised in the supervision of the milk and food supply.

We probably have need for the immunization of ten thousand more persons under twenty-one years of age before we may rest on our oars and make the disease a rare one. More than half of these persons are in the pre-school age group and might be cared for by the family physician.

Much credit for any success belongs to the Gary physicians, to the Board of Health, to the school nurses who have told pupils and parents of the opportunities offered them, to the Gary *Post-Tribune* for its publication of many articles, not only local in character, but the syndicated articles from the American Medical Association; the State Medical Association, the U. S. Public Health Service and other organizations.

TABLE NO. I

Table Showing Total Number of Schick Primary Tests August, 1924, to January, 1928, Public Schools, Gary, Indiana

Year	Pos.	Comb.	Neg.	Pseudo	Total Read	No Reading	Total Tested
1924-25	1156	18	1394	263	2831	69	2900
1925-26	742		617	28	1387	505	1892
1926-27	1045		836		1881	214	2095
Sept., 1927, to Jan., 1928	140	1	190	7	338	33	371
TOTAL	3083	19	3037	298	6437	821	7258

Total Positive and Combined 3,102, or 48%
Total Negative and Pseudo 3,335, or 52%

TABLE NO. II

Table Showing Total Number of Schick Retests Read from August, 1924, to January, 1928, Public Schools, Gary, Indiana.

Year	Pos.	Neg.	Pct. Pos.	Pct. Neg.	Total
1924-25	30	33	48	52	63
1925-26	105	348	23	77	453
1926-27	262	682	28	72	944
Sept., 1927, to Jan., 1928	101	107	49	51	208
TOTAL	498	1170	30	70	1668

TABLE NO. III

Table Showing Number of Cases of Diphtheria Reported to Board of Health, Gary, Indiana, Number of Deaths from Diphtheria, and School Census, 1917 to 1927.

Year	Number of Cases	Number of Deaths	School Census
1917	122	20	9,811
1918	202	35	11,167
1919	128	14	12,137
1920	120	11	13,447
1921	214	13	15,331
1922	65	6	15,217
1923	101	16	16,664
1924	95	6	18 438
1925	105	3	20,472
1926	74	5	23,210
1927	38	5	24,852

THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS*

Gerald B. Webb, M.D.
Colorado Springs, Colo.

The chain of thought which will lead a physician to the successful early diagnosis of pulmonary tuberculosis must resemble the firmly fixed chain by which Aristæus held Proteus when he changed in rapid succession into fire, flood, and a horrible wild beast. The links of the chain are composed of the constant thought, "tuberculosis," no matter what protean sign or symptom the patient presents. In the case of practically every disease the physician must consider the possibility of tuberculosis. He should expect to be able to make an exact diagnosis of tuberculosis in at least two percent of his clientele. Easy exhaustion, digestive disturbances, headaches, nervous irritability, insomnia, fever which at times may resemble typhoid, tachycardia, malaise, anæmia, weight loss, pain in the chest, local and general sweats, frequent throat clearing, fistulæ, blood spitting, susceptibility to colds, dry or productive cough, disorders of menstruation, are some of the symptoms and signs which call for most careful investigation for pulmonary disease. The most important part of the study of each patient is the careful taking of the history. The next most important step is the close scrutiny of the patient by the trained eye of the clinician. It is a stigma on the medical profession that lay people who have been closely associated with the tuberculous, as in a health resort, can recognize a consumptive type long before many physicians can make an exact diagnosis. The toxin of the disease creates objective and subjective signs such as wasting of the neck muscles, flushed cheeks, glistening eyes, a delicate appearance, easy fatigue, temperamental disturbance and even a weakened voice; any of which should arouse suspicions of tuberculosis. On the other hand, advanced tuberculosis may be present in some people with absence of all such symptoms.

*This authoritative article is published at the request of the Indiana Tuberculosis Association as a contribution to the "Early Diagnosis Campaign."

Physical Examination: Inspection will reveal a lagging of one or both lung apices.

Palpation enables a confirmation of possible lagging, determines the excursion of the chest wall, detects the increased or decreased vocal resonance, the position of the heart apex beat, which may be changed by a diseased lung, and the position of the trachea, whether misplaced to right or left. Percussion is valuable in detecting impaired resonance at the lung apex, and percussion with the tips of all five fingers, as advocated by Auenbrugger, who introduced the art, is very valuable over the bases of the lungs to bring out basal lesions, thickened pleura or pleurisy.

Auscultation is probably the most important means of investigation. Changes of the breath sounds such as prolonged, high-pitched expiration, quiet breathing and rales are to be noted. It is best to begin auscultation by placing the stethoscope in the lower axilla, and moving the bell upward after each expiration. To determine the presence of rales the patient should be instructed to breathe in through the mouth, then to breathe out and to give a slight cough with the last part of the outgoing breath. Rales are apt to be heard in showers, and usually occur after the cough at the time the breath is inspired. They should especially be sought at the apices posteriorly and above and below the clavicles. It must be remembered that occasionally the residual fractions of the broncho-pneumonias of influenza may for a while give rise to a shower of rales similar to tubercle.

X-ray Examination: The x-ray films should always be inspected by the clinician. Special technic is needed to produce proper x-ray pictures of the chest and it is a serious matter that so many poor films are taken. The x-ray may indicate that tuberculous lesions found on physical examination are actually more extensive or at times less extensive. Areas of tubercle deposits are found frequently in healthy people at the roots of the lungs. The films should be inspected carefully for tubercle lesions in the parenchyma of the lungs.

Fluroscopic study is of value in noting the lung æration and the excursion of the diaphragm. Early diagnosis rarely can be made by the fluoroscope, and, generally speaking, film study is the more essential.

Laboratory Examinations: Specimens of sputa should be taken and sent to a reliable laboratory. At times many specimens are necessary before a positive diagnosis can be made. Patients often relate that, suspecting their own conditions in spite of negative findings by their physicians, they have of their own accord sent sputa to public laboratories and the correct diagnoses have been made. There are no reliable blood tests for the detection of tuberculosis. An increase in the white cell count and a decrease, or at times increase, in the total lymphocyte element are at times suggestive.

Temperature Study: Any person suspected of pulmonary tuberculosis should be put to bed for at least a week and the temperature and pulse studied carefully. One or two temperature observations at the time of office visits are most unreliable. An afternoon or evening temperature of 99 or over needs explanation. The resting pulse should be normal in a healthy person. In patients with tuberculosis it is almost always accelerated.

Tuberculin Tests: The skin tuberculin tests have no value in the diagnosis of adult tuberculosis. The subcutaneous test can be dangerous and should be used by experts only.

Differential Diagnosis: Almost any disease from hookworm to aneurysm may suggest tuberculosis. Repeated negative sputum findings should always lead to a careful search for bronchitis or bronchiectasis associated with infection of the nasal accessory sinuses. In such cases the rule should be to order x-ray pictures of the sinuses. Lung abscess, and rare chest diseases such as aspergillosis, streptothricosis and even syphilis, are conditions the tuberculosis specialists are constantly watching for. Thyrotoxicosis is a condition which may resemble tuberculosis, especially in weight loss and in fever and pulse variations. A definite increase found in the metabolic rate determines the diagnosis in favor of hyper-thryoidism. Possibly the greatest difficulty in differential diagnosis is found among patients in whom occult tuberculosis is suspected. They may have no cough and present no physical signs, and parenchymatous lesions of the lungs are not detected by the x-ray. In these people, most frequently women, a daily elevation of temperature is noted and also an accelerated pulse. A careful investigation must be made in regard to the thyroid gland, tonsils, teeth, gall bladder and pelvic organs before a diagnosis of occult tuberculosis is made. Tonsils should not be removed, especially in adults, unless a very careful study of the chest has been made.

The early diagnosis of pulmonary tuberculosis would be made more often if physicians would keep uppermost in their minds the frequency of the disease and their responsibility to be constantly alert to the possibility of tuberculosis in so many maladies for which they are consulted.

SPECIAL ARTICLE

"PERIODIC HEALTH EXAMINATION"*
(Article I)

Because of the growing interest in the periodic health examination movement, the Bureau of Publicity of the Indiana State Medical Association has prepared a series of four bulletins dealing with the definition, history, object, necessity, methods, difficulties, results and the growing success of the movement.

This first article explains what the periodic

*This article is prepared by the Bureau of Publicity of the Indiana State Medical Association and is published at the request of the Bureau.

health examination movement is and tells something about the history of the periodic health examination movement and the attitude of the medical profession in regard to it:

Periodic physical examinations of all persons have been recommended by progressive physicians for many years. The original suggestion seems to have been made more than a half century ago, but only recently has the movement received the impetus which promises to make it a real and important factor in the development of the nation. Periodic health examinations for life insurance companies were suggested about 1870 by a Dr. Dobell in England, and Dr. Bares, a French hygienist, urged them twenty years ago. In 1909 Dr. Burnside Foster submitted to the Association of Life Insurance Medical Directors a definite plan of life conservation which included a recommendation for periodic physical examinations every five years. The American Medical Association, representing the organized profession, went on record in 1922 and again in 1923 as favoring periodic medical examinations of the apparently healthy.

Importance of prenatal examinations, examination of infants and school children has long been admitted. The benefits of army and insurance examinations have long been known. The time has come to pay some attention to the average individual who does not feel quite up to snuff but considers himself generally well, and for that reason physical health examinations are being urged for the average man. The army draft during the World war is the only real national physical examination which this country ever has had and by applying the basic principles used in the army examination, physicians claim that anyone can be helped by wise, scientific advice to reach his normal expectancy of life.

A health examination is a thorough physical and mental appraisal of the individual by a competent doctor of medicine to ascertain physical and mental impairments and faulty habits with a view to their correction. It is a survey—an audit of one's physical assets and liabilities. Nowadays we find people coming to physicians in increasing numbers to have an estimate of their state of health and for specific advice to avoid the disabilities of advancing years.

The importance of periodic health examinations has not been fully grasped even by some members of the medical profession. Occasionally, a physician when called upon to make a periodic health examination is busy and inclined to tell the patient he is all right and has nothing to prescribe for him, whereas the patient called for a personal check-up on his condition as a matter of bodily bookkeeping and not because of illness.

Doctors are busy men and universally prefer to examine patients who have some known actual ailment. In order to overcome this, the American Medical Association has issued a manual prepared by leading physicians giving in detail an up-to-date method of physical examination. It also has prepared standard forms for the use of physicians. The health examination aims to omit no details and for the purpose of uniform and complete examinations, these forms are available for all physicians. The scheme makes the intelligent family doctor an adviser in health as well as a physician in illness.

IDENTIFICATION OF NEW-BORN BABIES IN MATERNITIES

An interlocking system of safeguards for identification of new-born babies in maternities is described by Joseph B. De Lee, Chicago (*Journal A. M. A.*, Jan. 21, 1928). When the parturient enters the birth room, the surname of the father, his given name and that of the mother are written in the time-book. This book is kept by the assisting nurse, who enters in it the time of the rupture of the membranes, the time of the delivery, the sex and weight of the child, the time of delivery of the placenta, the final position and presentation, the nature of the birth, the name of the physician, the name of the nurse who "scrubbed," *and the naval-wrist number,* with information for other purposes. 2. When the baby is born, the cord is tied with a sterile tape bearing a numbered aluminum tag, the physician calling the number out loud. Before the cord is cut, the clean nurse ties the tape bearing the same number around the baby's wrist, also reading the number in a loud voice, and hands a third tape to a bystander to fasten on the mother's wrist. This last assistant repeats the number so that all can hear it, especially the timekeeper, who puts it down in the time-book. Any disagreement in the original numbers is thus discovered at once. This navel-wrist number is now associated with the name in the book. The cord is cut, and the child is placed in its crib. 3. A nurse at once fills out the printed blanks on the adhesive plaster, and affixes it to the infant's back. The plaster has the surname of the father, his and the mother's given names, the physician's name, the sex of the baby, its date of birth, *and the navel-wrist number.* At the same time, the birth and sex of the child are telephoned to the office and the child's hospital entry number is obtained and recorded in the time-book on the history sheet. The words "son" and "daughter" are used, two unlike terms, to avoid a mistake in transmission. Only now may the child be removed from the birth room to be weighed, dressed and measured. 4. The footprints are made after these data have been obtained. We tried taking fingerprints but it proved unpractical. Two copies of footprints are supplied, one on the mother's labor record and one on a pink sheet of paper, given to the mother to keep. This slip has the name and sex of the baby, its birth weight and date, the name of the physician who delivered it, *and the navel-wrist number.* When the child reaches the nursery, its crib-card is written out. This has the name, sex, date of birth, name of the physician and navel-wrist number. Before the umbilical stump has fallen off, which, of course, takes with it the numbered tag, the mother has usually learned to know her baby. If she has not, the wrist number and the adhesive plaster on the back will help her. The nurses are taught to read the back plaster before the baby is sent up for circumcision or sent home. In all cases, the baby goes home wearing the wrist number and with the adhesive plaster still on its back, and usually the mother claims and keeps the navel tag and wrist tape together with the baby's footprints as fond souvenirs. In a case in which the identity of the child is doubted, it would be easy to trace it back through a maze of records and to present an array of evidence that no jury could question.

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EDITORIALS

THE DANGERS OF SOCIAL WELFARE

We have been accused of pessimism concerning the future standing of scientific medicine and the economic position which the individual physician of the near future will occupy in the body politic. Perhaps all that we have said concerning the dangers of prevailing tendencies is like a vain cry in the wilderness, though we at least have the feeling that we are performing a duty in attempting to arouse the members of the medical profession individually and collectively to a recognition of the slow but insidious manner in which the high aims of scientific medicine are being thwarted and the economic position of the individual physician in society lowered. Not only do we have to fear the growing tendency toward the establishment of so-called state medicine, which term interpreted means the furnishing of all medical and surgical service by municipal, state, or federal agencies, and at little or no expense, no matter what the social or economic status of the recipient may be, but we also have to fear the inroads that are being made upon the private practice of medicine by the work of a variety of welfare agencies that originally started out to render service to the indigent and the deserving poor, but have so broadened their activities that they include not only all who seek their service but all who can be induced by any specious plea to accept it.

Most of these welfare agencies started out with laudable purposes and good intentions; many of them originated by philanthropic laymen with an "I am my brother's keeper" idea in the forefront, and with the endorsement and even active support of some of our most reputable and talented medical men who believed that it was right and just that the deserving poor should have the very best medical care and attention for their ailments, and that perhaps welfare organizations offered the most practical manner of securing the results. These enterprises flourished and in the beginning did a very commendable work, but as some of us predicted, they soon expanded and enlarged their sphere of usefulness by abandoning restrictions and accepting all who presented themselves for attention and asking no questions. Eventually mild protests came from medical men concerning the change of policy, but the welfare organizations, sleek and prosperous from liberal donations wheedled out of well-meaning philanthropic individuals, became arrogant and replied that if those medical men who had been giving support to the enterprise did not care to cooperate then the organization would find other physicians who would. And they did! Younger men, desiring experience and a living, or older ones who desired to maintain the questionable prestige derived from connection with these agencies, sold their souls for a mess of pottage. The well-paid manager, secretaries, and attendants dictate the policies, and the physicians, giving of their time and talents gratuitously or for niggardly compensation, dance when the whip is cracked.

Some of these so-called welfare agencies do not give any accounting of the funds donated by well-to-do philanthropic persons, or if they do give an accounting it is a distorted and untrustworthy one. It is but natural that the commercial possibilities of such a program would be seen by some of those acquainted with the workings and the ease with which the very necessary service of the medical profession can be secured, and in consequence there developed the purely commercial organization parading under the name of a welfare organization and presumably having the patronage and support of well-to-do philanthropists. One of these institutions that we know about was promoted by a frank statement to the effect that all of the people are entitled to the very best medical and surgical attention procurable, and that through organization and proper financing such could be given to the people not only at a very low cost but with adequate return to those financing the project. Originally the enterprise started out with the idea that all applicants for service would be charged fees consistent with ability to pay, and on this basis a few reputable physicians, most of them well established socially and economically, gave their endorsement and support. They found comfort and a certain cheap kind of glory in being advertised as sponsoring such a worthy (?) object. However, it was not the intention of the promoters to do anything more than get started under such favorable circumstances before resorting to rankly commercial methods to practice medicine on the department store style. The reputable medical men connected with the institution became disgusted and resigned, but the enterprise has not encountered the slightest difficulty in finding younger and even capable men who are willing, at niggardly salaries, to work in order to make a living, or in the vain hope of gaining experience and of establishing a professional reputation. From more or less modest advertising in the lay press and before various civic organizations the plan of getting business turned into that of personal solicitation through an adroit system of nurse-inspection. This resolved itself into visits to the private homes where illness was reported or suspected, and in personal interviews on the street or in offices and places of business. Even the periodic examination stunt has been worked to a finish in securing patients, and ministers and churches have been among the most gullible in accepting

what was offered as a godsend to the sick and afflicted. Reputable and established physicians not connected with the enterprise have noted that their patients actually were solicited by the welfare organization to become patients and take advantage of the so-called "complete service" at low cost. The quality of service rendered deteriorated, as would be expected under such a system, but has been made good enough to satisfy the general run of people, and in consequence the enterprise flourishes from a commercial standpoint. The reputable men of the community have been forced to see the size of their practices and incomes dwindling. They still retain their patronage among those well-to-do who rather scorn things that are cheap, but there are always enough people, many of whom are well-to-do, who are willing to attempt to get something for nothing, and in the final analysis the continuation of the welfare clinic spells disintegration of the medical profession in general and a lowering of the standard of scientific medicine.

What has happened in the actual instance cited can happen in any community, and in fact is happening in ways that are analgous to the one described though perhaps less fully developed. "Well, what are you going to do about it?" someone asks. Nothing—except to point to "the handwriting on the wall," as we have been pointing for so many years, and putting forth every effort to influence reputable medical men individually and collectively to stop giving endorsement, comfort, or aid to any of these welfare enterprises, organized and sponsored by laymen, and for the most part conducted by well-paid lay managers, secretaries and others who have warped consciences and little or no respect for physicians except to use them as menials. Never in the history of the world has regular medicine ever refused charity to the indigent, or exhibited an unwillingness to render professional services to the deserving poor for fees consistent with the ability of the patient to pay. In spite of this, no class of people following any vocation has ever been more imposed upon than physicians. This is true in connection with services rendered many individuals in times of sickness or distress, but is also true in connection with all of the various worthy and unworthy welfare movements. We believe that it is high time that the whole subject of medical charity of every kind and description shall be taken over and managed in its entirety by the medical profession, with the aim in view of giving the best possible service to the indigent, without money and without price, and all others at fees consistent with the ability of the patient to pay. It must be divorced from lay control or domination insofar as medical service is concerned. In carrying out this plan it will be necessary to reprimand and even penalize those physicians who have so lost their self-respect and their knowledge of what is necessary for their own economic advancement or salvation as to listen to the pleas of or accept offers from any of the various organizations conducted under whatsoever specious object, who would destroy the professional standing and independent economic position occupied by medical men.

We offer this prediction: that unless the medical profession awakes to the dangers that threaten, it will not be ten years before the majority of the medical men of this country will be occupying little better than clerical positions, and with clerical incomes, and scientific medicine for the masses will have greatly deteriorated as a direct result of the loss of independence, incentive and self-respect of the individual physician.

ARGYROL EQUIVALENTS

Argyrol is now omitted from "New and Nonofficial Remedies" of the A. M. A. In explanation it is pointed out that the history of this preparation is another example of the manner in which clinical evidence, not too carefully obtained, may boost a new remedy into popularity beyond its due. Few physicians realize the resemblances which exist between argyn, argyrol, cargentos, silvol, and vargol. *The Journal of the A. M. A.* says that it is important for the general practitioner to know that these products are essentially the same, that they accomplish almost the same thing, and they are used for essentially the same purposes. All of these preparations now are included in the heading Argento Protenium Mite, or Mild Silver Proteins. They differ slightly in composition, but are essentially equivalent therapeutically. The report goes on to say that the Council has examined calmly and dispassionately the therapeutic claims made for argyrol, and has been unable to find evidence for some claims which it terms essentially misleading. Furthermore, the manufacturer apparently is unwilling to adopt the pharmacopeia synonym for it. The insistence on this term is important so that physicians may fully comprehend the nature of the substance that they are using.

From a purely personal point of view we never have been able to discover that any of the so-called newer silver salts had any appreciable difference in therapeutic value, and argyrol, which we have used extensively, has never appeared to us to be any better than silvol, which we also have used extensively, or any of the other newer silver salts which we have used occasionally. We are pleased to know that the Council on Pharmacy and Chemistry finally is giving an official and trustworthy opinion on the subject.

INCOME TAX IMPOSITIONS

In an earlier number of The Journal we commented on the attempt of some of the Indiana assessors to compel physicians to turn in their book accounts for taxation, and pointed out the injustice of the practice if put into effect. Now comes another attempt to impose upon physicians through an effort, already started by the chief

internal revenue office of Indiana, to squeeze additional taxes out of those physicians who employ one or more assistants. The specious argument is made that inasmuch as the assistants earn more than they are paid, the amount of profit accruing to the head or heads of the institution should be divided into two classifications, earned and unearned income. Two well-known Indiana physicians who made their income tax return on the basis of earned income only were advised that the report would not be accepted because the proceeds derived from the assistants, over and above that paid in salaries, should be classed as unearned income and, therefore, subject to a higher rate of taxation. A formal protest has been filed with the revenue department and it is expected that the entire matter will be referred to Washington for decision.

It is admitted by the local revenue office in Indiana that the case is to be a test case, but the decision is of vital interest to each and every physician in the United States who employs one or more assistants in his work. Whether this effort on the part of an internal revenue collector for Indiana is inspired by the belief that making the attempt successful will result in promotion or other favorable consideration is not worthy of extended comment. The fact of the matter is, definite action has been taken to compel thousands of physicians to pay additional taxes which in our judgment are unjust, illogical and discriminatory. Patients come to a physician or a firm of physicians for services, and hold the physician or physicians responsible for the kind and character of service. In a majority of instances they do not know the assistant or even that assistants are employed in the office to which they go. The fact that those assistants render a more or less personal service to the patient, for which service the patient is expected to pay, in no way alters the fact that the service has been rendered under the direction and responsibility of the head or heads of the office, and it is an established point in law that the head or heads of an institution are legally responsible for the acts of the assistants, insofar as such acts pertain to the routine work of the office. It is quite probable that in the majority of the offices the charges to a patient are not separated sufficiently to show what portion of the fees cover services partly rendered by assistants, and, anyway, it would be difficult to make a distinction when the final decision as to kind and character of treatment rests with the chief, and when upon him rests the responsibility, morally and legally, for the attention given. It would be difficult if not impossible to separate income into earned and unearned classifications to meet any such requirement for physicians as that proposed. Furthermore, this attempt to impose discriminatory taxes upon physicians, if carried into effect, will lead to a broadening out so that it includes lawyers, dentists, architects, engineers, and in fact all forms of business where assistants on salary are required.

Our sympathy goes out to the two Indiana physicians who seem to have been singled out as the ones upon whom this tax imposition is to be tried out, for to fight the matter means a loss of time and expense that few men desire to stand. It would be far cheaper to pay the amount of tax unjustly imposed, but there is a great principle at stake which should be settled on the side of right for the benefit of the entire medical profession of the country. Therefore, we hope that this case will bring forth the united support of the profession and in particular the legal department of the A. M. A. in a decision that ignores unearned income in connection with actual medical practice. Already physicians as a class are unduly taxed by being prohibited from making deductions that logically belong to them, and which are permitted in any other vocation. Physicians are quite willing to pay additional taxes upon income from productive property, but do object to being singled out as easy marks for an unjust tax upon their labor.

INDIANA'S MEDICAL CENTER

On Sunday, December 18, 1927, an editorial appeared in the Indianapolis *Star* calling attention to the medical center which is being developed in Indianapolis and emphasizing the justifiable pride which Indianapolis has in that center. Indianapolis does take pride in this medical center, for it consists in part of the Indianapolis City Hospital, which in recent years has been almost completely rebuilt and modernized and for which a building program of a million and a half dollars recently was voted. The state of Indiana, however, with equal justification, prides itself on this medical center, for a very considerable part of it is made up of the school and hospitals of the Indiana University School of Medicine. The two sites are immediately adjacent. The School of Medicine site consists of something more than fifty acres. The City Hospital site consists of about twenty-five acres. This joint campus is surrounded by approximately one hundred and twenty-five acres owned by the City of Indianapolis, the parking of which already has begun. No medical center of the world has a setting of such acreage.

This whole development is very recent. Twenty years ago the School of Medicine occupied part of a block down town next to the State House. The school had no hospital of its own. The City Hospital, used for clinical teaching, was old and was a fire hazard. Following the union of the five old medical schools of Indiana under the leadership of Indiana University in April, 1908, the present site was acquired.

The first building erected upon this site was the Robert W. Long Hospital, opened for patients in June, 1914. A new medical school building was erected next, occupied for the first time in the fall

of 1919. This was followed by the James Whitcomb Riley Hospital for Children, opened for patients in November, 1924. The Riley was built on a site of about thirty acres connecting the Medical site with the City Hospital site. The Riley, though still incomplete, has beds for two hundred patients. During the past year almost a million dollars of new buildings have been added to this medical site. The first of these, the Coleman Hospital for Women, than which there is nothing better in hospital construction in the world, was opened for patients in November, 1927. This hospital, the gift of Mr. William H. Coleman and his wife, cost in excess of three hundred and fifty thousand dollars. A training school for nurses, for which a gift of half a million dollars was made by the Ball brothers of Muncie, is rapidly nearing completion.

A hundred thousand dollar addition to the School of Medicine was used first in January of this year. The hundred thousand dollars for this addition, voted by the last legislature, is the sale price of the old medical site adjacent to the State House, and continues in perpetuity the spirit of the donors of the original medical building, whose thought it was that their original subscription should provide continuously for medical education. So much for the mere physical plant of this medical center.

The importance of this medical center may well be gauged by the fact that during the past year there were four hundred and sixty applications for matriculation in the freshman class of the Indiana University School of Medicine, which at present has a maximum capacity of one hundred and fifteen freshman medical students.

Although barely twenty years old as a four-year medical school, the Indiana University School of Medicine this year ranked fifteenth among the medical schools of America in point of total number of applications for freshman matriculation. The total was only six less than that of Harvard and exceeded materially all of the schools of this northwest territory with the sole exception of the University of Michigan. This is a very remarkable recognition on the part of students of the merits of our state school. That this reputation is justly merited is evidenced by a study of the product of the school—that is, the medical graduates—in their performance before the state boards.

The high standing of the graduates of the Indiana University School of Medicine is due largely to the high grade instruction given in the various departments of the school. It also is due, however, to the careful selection of the members of the freshman class and the careful elimination in the first two years of the school of medicine of those students who are lacking in application or in ability to carry the work of the medical school.

It will be noted that hospitals have been provided entirely through gifts, some great, some small. To the Riley Hospital more than 20,000 contributed. Buildings and attendance have grown out of proportion to income. Maintenance budget must be increased in order that this great plant may serve the people of the state with maximum effectiveness.

A CROOK PROVES GULLIBILITY OF SURGEONS*

Professional as well as business men must be on guard constantly to avoid becoming the victims of crooks and shysters. It is no doubt true that business men are far more critical of propositions presented by unidentified strangers, or those without responsible connections, than are physicians. They have, of course, learned to be wary, and doctors would be wise to practice a like degree of skepticism when confronted with bizarre and unusual propositions.

Usually the crook has something to sell, but the latest procedure coming to our attention varied the program by expressing a desire to buy. As a doctor has nothing to sell except his professional services, the success of the plan depended entirely upon an appeal to a weakness that reflects no great credit on the victimized physician. No one but surgeons were approached, probably on the theory that a prospective surgical fee was sufficient inducement to mellow the surgeon into a receptive mood when a request for a loan should be made. The well-dressed stranger, with foreign accent, enters the surgeon's consulting room with the following story: "I have been referred to you as a good surgeon. I have known for some time that I have appendicitis and will have to be operated. At this time I have a very severe pain in my side. I should like to have you examine me and if you think it advisable arrange for an operation."

Just how much of an examination is done to verify the suggested diagnosis, deponent sayeth not, as the available records on this particular point are exceedingly meager. However, in each and every instance the diagnosis is confirmed and an operation recommended. At this juncture, the patient, considerably embarrassed, and no doubt fatigued by a constant and nagging pain in his lower right quadrant (?), shows a certified statement of a bank account in another city, ample to pay his hospital expenses with a pleasing margin for a surgical fee. However, he is a stranger in the city and is short of cash to care for his hotel bill pending his admittance to the hospital. "Will the surgeon not advance him $10 or $15 for this purpose?" "Why, yes, I will be glad to do so."

We are reliably informed that this man, under different names of course, was scheduled in the same hospital by three surgeons. How much money he got, the record is again silent, but we strongly suspect the unfortunate patient with a

*A later report is to the effect that the crook in question was fined and sentenced to thirty days in jail for obtaining money from Indianapolis surgeons under false pretenses. It is reported that the duped surgeons refused to appear before a grand jury for investigation of the crook's activities.

troublesome appendix had a fairly profitable day in our capitol city.

An inquiring mind might find much food for thought in this episode. Is it true that a diseased appendix is so obscure a condition that one is forced to rely entirely upon the diagnosis of the patient to determine its presence? Is it true that the value of a patient's unchecked story of his illness as an aid to diagnosis and treatment, especially in surgical conditions, increases in direct ratio to the size of the fee? Or is it possible that the surgeon's *tactus eruditus* is a trifle dulled, or his confidence in laboratory aids to diagnose is a bit below par when a sizable fee is in sight? We will not attempt to answer these queries, but only suggest that the crook in this story had no doubt as to the probable answer, and his experience abundantly justifies his suspicions.

PERHAPS THE LORD LOVES A CHEERFUL LIAR

An actual case: The ship had been plunging and rolling in a turbulent sea for three days. A female of uncertain age, bearing an expression of misery, had stuck closely to a steamer chair except for brief intervals during which she hung over the rail complying with the urge of her dreadfully seasick stomach. The deck steward vainly had tried to induce her to partake of hot broth or other nourishment, but she flatly refused. Most of the time one could see in her hands a copy of "Science and Health with Key to the Scriptures," but she did not read it. On the fourth day the sea became calmer, the ship sailed along peacefully without plunging and rolling, and gradually the passengers began to show life and animation. In neighborly chats they were recounting their experiences when Mrs. Eddy's disciple was heard to remark: "You know, dear, so-called seasickness is merely imagination. Throughout the storm I never felt better in my life, and I owe it all to my faith in Christian Science." A bystander who had noted the pitiful condition of the Eddy disciple during the storm that had been passed through, was heard to remark, "Perhaps the Lord loves a cheerful liar."

THE PHYSICIAN IN POLITICS

As a usual thing the physician takes little interest in politics. Now and then some member of the medical profession has political aspirations and seeks office, but the rank and file of the profession exhibits little interest in political preferences or the reason and consistency of certain political issues. Physicians may read the newspapers and discuss politics, but the majority of them, like so many people following other vocations, walk up to the polls and vote a partisan ticket because they started out to vote that way and are not inclined to break the precedent. This is radically wrong in that not enough attention is given to that side of politics which has to do with the best interests of medical men individually and collectively even though no attention is given to issues that have to do with the common good. There are great questions pertaining to the scientific and economic advancement of the medical profession, as also questions pertaining to public health, sanitation and the establishment of educational requirements for the practice of medicine, which should be of interest to medical men as well as the public. These questions, many of which are to be settled directly or indirectly by ballot, are of sufficient interest to justify the physician in weighing them carefully with the idea in view of electing public servants who will carry into effect the programs that seem to be needed from the standpoint of medical men. Surely partisan politics should not be the guiding star for medical men to follow, for if each and every one of us vote either the republican or democratic ticket because of allegiance to either of the political parties represented we are narrow indeed in our viewpoint.

Recently The Journal was called to task by a lay paper for having pointed out the inconsistency of voting for a republican congressman who has shown that he is not in sympathy with some of the high aims and principles of the medical profession, and the specious opinion was advanced by the lay paper that medical periodicals should confine themselves to medical subjects. Such an opinion is inconsistent in view of the fact that medical men have just as much right to their opinions as anyone else, and they are derelict in duty when they do not openly approve or disapprove the public issues that have to do with those enterprises that are sponsored by the medical profession, or in keeping with the traditions and policies of the profession no matter by whom sponsored. No just criticism can be offered concerning the decision on the part of a physician to vote against a candidate for office who by action and words is opposed to that for which reputable medical men stand. It is not a question as to whether a man is a democrat or a republican, but a question of principle. The established tendency on the part of human beings is to work for their own interests, and medical men are justified in working for their interests, which in the final analysis is the public's interest. Medical journals have just as much right to discuss party tickets from the standpoint of the good that will come to medical men as have lay periodicals in discussing political issues from any standpoint. In the article criticized in the lay press, The Journal pointed out the reason why physicians in the Twelfth Congressional District should hesitate to vote for the return of Representative Hogg to Congress. The question was not discussed from a partisan standpoint; in fact the editor of The Journal for many years has been classed as a republican, has given of his time, talents and money to the republican party, and volunteered the information that he voted for Representative Hogg in the last election. The Journal never

will discuss partisan politics from a partisan standpoint, but it does propose to show up those candidates for office who with oily tongue and smiling face are seeking the patronage of medical men while at the same time opposing every principle and policy for which scientific medicine stands. We don't care whether a candidate for office is a democrat or republican, we propose to ask the members of the medical profession *not* to vote for him if he is known to be opposed to the various things pertaining to the practice of medicine or to the promotion of public health measures that are supported by the medical profession. When a candidate for Congress will uphold the rankest kind of quackery and charlatanism, which all right-thinking people recognize as a menace to the public and particularly the poor and ignorant of the public, and when that same candidate for congress speaks reproachfully of educated and trained medical men, it is time for the physicians to take the measurement of that candidate, whether he be a democrat or republican, and try to bury him in the political grave where he belongs.

THE SHEPPARD-TOWNER ACT

Last month the Indiana Child Welfare Association held a meeting in Indianapolis, at which there was a somewhat spirited discussion concerning the Sheppard-Towner Act and the continued use of Federal funds to carry out in Indiana the activities that have been promoted by the act. It isn't very strange to learn that the strong supporters of the Sheppard-Towner Act have statistics all their own, and are not willing to trust anything else, no matter from what source derived. This was shown when the statistics of the A. M. A. were questioned. At the meeting were representatives of the Indiana State Medical Association, especially appointed to discuss the Sheppard-Towner work with the Indiana Child Welfare Association, and this committee, through its chairman, Dr. W. N. Wishard, of Indianapolis, presented a written statement which represents the opinion of the medical profession generally, not only of Indiana but of the United States, concerning the continuation of federal aid to support child welfare work. Dr. Wishard's letter presented to the Child Welfare Association is as follows:

March 16, 1928.

Mr. Thomas A. Hendricks, Ex. Sec'y,
Indiana State Medical Association,
804 Hume-Mansur Building,
Indianapolis, Indiana.

Dear Mr. Hendricks:

I regret exceedingly that I cannot accept with you the kind invitation received to attend the luncheon meeting of the Indiana Child Welfare Association today at the Lincoln Hotel.

I am writing you this letter, which you are at liberty to use as expressing the views repeatedly promulgated by the American Medical Association, and endorsed and entertained by the Indiana State Medical Association and all the county auxiliary societies thereof.

A meeting was held in your office day before yesterday of the members of the Committee on Public Policy and Legislation of the Indiana State Medical Association at which time a special committee, consisting of Dr. F. W. Cregor, Dr. H. H. Wheeler and myself, was appointed to consider further questions relating to the Sheppard-Towner bill as referred to in the letter recently received by you from Mrs. Edna Hatfield Edmondson representing the Child Welfare Association of Indiana.

The question to be considered at the meeting today seems to be whether to approve continuance of the Sheppard-Towner bill or to concentrate efforts toward securing a greatly increased state appropriation.

The questions involved are so complex and of such manifold ramifications that it is impossible to more than summarize the well-known views of the medical profession in reference to the Sheppard-Towner Act. The admirable work in child welfare work done in the various states, and notably in Indiana, directed by the enthusiastic and capable efforts of Dr. Ada E. Schweitzer, representing the State Board of Health and by the efficient aid of the Child Welfare Association, needs no eulogy from me. It speaks for itself. It is not a question of continuing or discontinuing this work but rather a question of adjustment and assumption of state responsibility for the state's own dependents.

The Sheppard-Towner Act involves federal approval and supervision of state activities. If the Federal Board happens not to approve the plans adopted in any state it can discontinue federal aid. The appropriation is based on the population of different states and arbitrarily assumes to pay an equal sum per capita regardless of varying health conditions if the federal board does not approve the adaptation of methods to the orders of any individual state. The act tends artificially to unbalance state health problems.

As a result of the operation of the Sheppard-Towner Act:

"In the birth registration area of the United States the infant death rate per thousand live births fell from 101 in 1918 to 76 in 1921 (the three years preceding the Sheppard-Towner Act). With the Sheppard-Towner Act in effect, it fell only from 76 in 1921 to 72 in 1924. The maternal death rate per thousand live births fell from 9.2 in 1918 to 6.8 in 1921, and during the next three years it fell from 6.8 in 1921 to 6.6 in 1924. In other words, the infant death rate declined 25 points in the three years preceding the enactment of the Sheppard-Towner Act and only four points in the three years following its enactment. The maternal death rate declined 2.4 in the earlier period and only 0.2 during the later. These figures are not cited to show that the passage of the Sheppard-Towner Act retarded the decline in infant and maternal mortality rates. They do show, however, that the act did not accelerate such decline."

Some comparisons of the operation in different states show strikingly the impossibility to adapt a different law to state needs in the paternalistic method involved in the Sheppard-Towner Act:

"Obviously, such states are not so much in need of subsidies as are the others. So far as figures alone afford a guide—and it is on the face of figures alone that the Sheppard-Towner fund is distributed—Oregon with an infant death rate in 1924 of only 53 per 1,000 certainly did not need a federal subsidy as much as did South Carolina with an infant death rate of 102. Utah with a maternal death rate in 1924 of 4.5 clearly did not need stimulation to improve that figure so much as did Florida, with a maternal death rate of 12.1. Nor is there any reason, so far as these figures show, why Oregon and Utah should be forced by the Sheppard-Towner Act to appropriate from their own funds for the lowering of maternal and infant mortality amounts of money in the same proportion, based on the total population, as might properly be required of South Carolina and Florida, if the Sheppard-Towner plan were workable on a logical basis."

The quotations in the preceding paragraphs are taken from the recent report of the Bureau of Legal Medicine and Legislation of the American Medical Association,

Dr. Wm. C. Woodward chairman. The report further states:

"If the state's plans for the hygiene of its mothers and infants are not pleasing to the federal board, no federal funds are forthcoming. If the federal board does not like the way the state is carrying its plans into effect, the board can discontinue federal aid. Each state must determine whether it will or will not accept the proffered subsidy and submit to federal supervision and control. Connecticut, Illinois, Kansas, Maine and Massachusetts have steadfastly refused to do so. The federal government is represented in the case primarily by the Children's Bureau, a lay bureau in the Department of Labor. The chief of that bureau, however, functions also as a member of the Board of Maternity and Infant Hygiene, her co-members being the U. S. Commissioner of Education and the Surgeon General of the U. S. Public Health Service. The administration of the act is entrusted to the Chief of the Children's Bureau, the board having authority merely to pass on the adequacy of state plans and activities."

President Coolidge, in his budget message submitted to Congress December 7th, stated as follows:

> "To relieve the states of their just obligations by resort to the federal treasury in the final result is hurtful rather than helpful to the state and unfair to the taxpayers. To tempt the states by federal subsidies to sacrifice their vested rights is not a wholesome practice no matter how worthy is the object to be attained.
>
> "Federal interference in state functions can never be justified as a permanent, continuing policy, even if, which is doubtful, such interference is warranted by emergent conditions as a temporary expedient. As shown in the maternity and infancy act, when once the government engages in such an enterprise it is almost impossible to terminate its connection therewith. We should not only decidedly refuse to countenance additional federal participation in state-aid projects but should make careful study of all our activities of that character with a view to curtailing them."

The American Medical Association is actively opposing the re-enactment of the Sheppard-Towner Act. It is not endorsed by the Indiana State Medical Association or any of its auxiliary bodies. If it were wise humanitarian legislation it would be impossible to restrain enthusiastic support of it by the medical profession. It is unwise national paternalism and supervision of health activities which properly belong to the individual states and hence the medical profession opposes it.

It would be a fine thing if the Indiana Child Welfare Association could unite in an appeal for a larger state appropriation for carrying on maternity and child welfare and other health activities and obviously lack of cooperation would be unfortunate.

During the last Congress the Senate amended the House Bill providing for two years extension of the appropriation for the Sheppard-Towner Act and cut it to one year with the understanding that it would cease at the end of that year.

I hope the real constructive and sympathetic attitude of the medical profession, both national and state, will not be misinterpreted and that cordial approval of constructive state legislation will be recognized as the ambition and desire of the medical profession.

Very truly yours,

WM. N. WISHARD,
Chairman, Special Committee,
Indiana State Medical Assn.

THERAPEUTIC LAMPS ADVERTISED TO LAITY

As we predicted in earlier numbers of THE JOURNAL some of the manufacturers of physical therapy apparatus are advertising their wares to the public, with misleading statements as to results to be obtained from physical therapy treatment. One manufacturer recently carried large space in the *New York Times* with the announcement that "10,000 doctors are using the ultraviolet lamp for aiding in restoring health, so why not have such a lamp in your own home?" We have received a complaint from one of our members to the effect that those manufacturers who are advertising direct to the public should be barred from representation in reputable medical journals. He makes the point that while there possibly is no harm in placing a therapeutic lamp or some physical therapy apparatus in the hands of a person of average intelligence, under the direction of a physician who understands their possibilities for harm, yet there is the possibility that it will be only a question of a short time until the advertising made to the public will include a lot of recommendations that sooner or later, as a result of the indiscriminate use of physical therapy apparatus, will result in a lot of harm to those persons using such apparatus without proper supervision. The point is well taken and is in line with some of the arguments we have advanced in the past concerning the manner in which self-prescribing is promoted indirectly through the action of members of the medical profession in giving the public suggestions concerning self-treatment. However, it is very difficult to suppress efforts to promote self-treatment on the part of the laity when physicians are so frankly taking their patients into their confidence concerning methods of treatment and comprehensive instructions as to how it is applied. An instance of this is the popularity of aspirin, made so by the fact that when aspirin was introduced to the medical profession the manufacturers were very careful to advertise it to medical men only and refrain from any publicity to the laity. Physicians began prescribing aspirin as an analgesic and sedative in a variety of conditions, and finally telling their patients to go to the drugstore and procure the drug themselves. Thus was self-prescribing promoted and the manufacturers immediately seized the opportunity to advertise aspirin to the public. What is true of aspirin is true of a number of other medicinal agents that might be mentioned. Therefore, just as long as physicians do not respect the old saying, "a little knowledge is a dangerous thing" and encourage self-treatment on the part of the laity, how can we blame the manufacturers for taking advantage of the situation, and what logical reason have we for offering complaint?

HOSPITAL STANDARDIZATION

We are getting just a little bit skeptical of the value of hospital standardization, and for the reason that no very definite rules seem to be followed, and some hospitals that have been standardized do not deserve the rating that has been given them. The American College of Surgeons has been particularly blatant concerning hospital standardiza-

tion, and its pretenses concerning this work, like all its other pretenses, are very laudable and if carried out would lead to great reforms. However, it is a well-known fact that some of the hospitals standardized by the American College of Surgeons are perfect hotbeds of commercialism, with fee dividing rampant among the members of the staffs. Of course we quite appreciate the fact that there are not a few of the Fellows of the American College of Surgeons who are *not* living up to their obligations and an oath which commits them to a non-fee-splitting standard. We have no sympathy for the man who makes pretensions to be good in order to get into good company and then when he gets into good company lapses back into his former practices. What applies to individuals applies also to hospitals. The truth of the matter is that neither individuals nor collections of individuals should be upheld when there is the slightest shade of suspicion concerning their ethics.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

Indiana should send a large delegation to the next session of the A. M. A., which is to be held in Minneapolis on June 11th to 15th.

A placard reading "Be your own physician and help the undertaker" should be placed in every home, and physicians should help the movement along.

We hope that no Indiana physician has accepted the bid of Macfadden for support by subscribing for *Physical Culture,* which magazine in so many ways has been opposed to modern medical practice.

During 1927 the percentage of physicians in Indiana who lived eighty-five or more years was 7.2, or the largest of any state in the Union. The most common cause of death was heart disease, with cerebral hemorrhage second.

If the recommendation of the California Fruit Growers' Exchange is followed generally perhaps it will be but a short time until the morning salutation will be, "Have you tested your urine this morning?", or "Have you had your morning dose of orange juice?"

A man who can at will change his systolic blood pressure from 110 to 260 resides in Fort Wayne. He has proved to be a human conundrum in the Mayo and numerous other well known clinics. The blood pressure variations depend upon position of the body.

"Dr. Richard M. Fluent, medical counsel of Transkutan, Inc.," was advertised to hold a clinic in Indianapolis at the Claypool Hotel on March 1st. We are just a little interested in knowing how many physicians "fell" for this questionable Transkutan therapy. Don't all answer at once!

We are pleased to note that the public is being advised from trustworthy sources of the dangers of indiscriminate use of ultraviolet rays. The April number of *Hygeia* contains an article entitled, "Be Careful with Ultraviolet." It points out some of the dangers. We hope that the article will receive wide reading by laymen.

When you purchase your ticket to Minneapolis to attend the next session of the A. M. A., secure from the railroad ticket agent a certificate which when properly certified to and validated will entitle you to purchase your return ticket home over the same route traveled to Minneapolis at one-half the fare paid for your ticket to Minneapolis.

If there are enough Indiana doctors who desire to go in a party to the annual session of the American Medical Association to be held in Minneapolis in June, our genial secretary, Tom Hendricks, will be very glad to arrange for one or more Pullman cars to go straight through from Indianapolis, or a special car can be arranged from any particular section of the state. Write Tom about it.

We hope that some of the county medical societies in Indiana have decided to penalize members who do not pay their dues on time. Neglect in the payment of dues usually is a result of carelessness, but that does not excuse the member, and if he knows he is to be penalized he will pay his medical society dues just as promptly as he pays his taxes, which also are subject to penalty if not paid on time.

The medical society of the District of Columbia has issued an invitation to the physicians of Indiana to make their society building, 1718 M Street, Northwest, their medical headquarters while visiting the nation's capital. Here will be found a library containing medical periodicals, daily lists of clinics held in the various hospitals, and opportunities for making personal contacts with the local medical profession.

Warning has been issued to physicians by *The Journal of the A. M. A.* to be guarded in furnishing information and subscribing for books containing flattering biographical statements concerning the subscriber. Of course such warnings have but little effect, as doctors are particularly susceptible to such flattery and are easy marks anyway. However, if a few heed the warning, money will be saved for them.

A cordial invitation is extended to the medical profession of Indiana to attend the seventy-eighth annual session of the Illinois State Medical Society which will be held at the Stevens Hotel, Chicago, May 8th to 11th, 1928. The program will consist of a combination of scientific and clinical meetings. Elaborate clinics have been arranged at the larger hospitals and at the medical schools of Chicago.

In the December issue of The Journal we commented on the quack remedy called "I-on-a-co" so-called electromagnetic therapeutic device developed by Gaylord Wilshire, the purpose being to magnetize the iron in the human body and reputed to cure all sorts of chronic diseases, including high blood pressure, arthritis, etc. It may be interesting to know that Wilshire died last September from one of the diseases that his apparatus is supposed to cure.

Not a few physicians think that they can tinker with nasal surgery. About the first thing they think of doing to correct obstructed nasal breathing is to haggle the inferior turbinates, and in consequence they do an infinite amount of harm, with permanent discomfort for the patient in many instances. Why can't they learn to leave the turbinates alone and tackle other causative factors with surgical attention if needed, or refer the cases to those who will do the proper work in a trustworthy way?

We hope that our readers appreciate the value of the article bearing on clinical laboratory service in the United States which was published in the February issue of The Journal. The report represents one of the very important pieces of work recently put into effect by the Council on Medical Education and Hospitals of the A. M. A. Its tendency is to prevent lay technicians, promoters, or others from presuming to dictate to or to advise physicians regarding matters which properly belong to graduates of medical schools.

If lay press comments can be depended upon the United States Public Health Service is condemning all tonsils, and bases the opinion upon an analysis of the findings in a very large number of cases observed over a long period of time. Analyzing this statement, we are led to believe that what really was the opinion concerning the subject is that there is no telling when resistance will be broken down, and the tonsils with their ever-present infection may be a disturbing factor in health.

The crook who feigned illness and arranged with several different surgeons to be operated (for a good fee, of course) reminds us of the story in *Judge* of two physicians who met and were credited with a conversation as follows:

First Physician: "What did you operate old man Smith for?'

Second Physician: "For five hundred dollars."

First Physician: "Yes, I know, but what did Smith have?"

Second Physician: "Five hundred dollars."

We are pleased to know that one of the manufacturers of physical therapy apparatus, incidentally being an advertiser in The Journal, announces that none of their products are obtainable except upon the prescription of physicians. They also are emphasizing the fact that no layman should attempt to diagnose his own case, but see a reputable physician first. This attitude is a little different than that followed by some of the manufacturers of physical therapy apparatus who are advertising direct to the public and with exaggerated claims as to curative effects.

For enterprise we commend certain insurance agents in Indiana who are soliciting physicians to take out policies covering protection to hands, fingers, and thumbs. Of course ten thousand dollars for the loss of the right index finger, or twenty-two thousand five hundred dollars for the loss of the right index finger and thumb would come in handy, and at an expense of fifty dollars per year would be a fine investment for the fellow that is injured, but we would like to know just how often medical men have an injury of that type. On the face of it, it seems that it would be a pretty good gamble for the insurance company.

Among some subjects a woman's auxiliary can talk about, the president of the Illinois auxiliary says that doctors' wives can help spread propaganda concerning abuses of all medical charities such as free dispensaries, infant welfare stations, etc. Also they can point out the constant trend toward paternalism which these things foster. Women's clubs in their willingness to help humanity sometimes fail to see the paternalistic side of many welfare movements. Through the women's clubs physicians' wives can assist in many ways in conveying the viewpoint of organized medicine to the public. To all of which we say, "Amen."

The surgeon-general of the U. S. Public Health Service has issued a warning against the use of vaccination shields. Studies covering several years show that shields or dressings are causes of severe "takes." They also delay healing and produce conditions which are favorable for the

development of tetanus that is caused by accidental contamination of the vaccination with soil, dirt, dust, etc. In New York state the use of shields by physicians in connection with vaccination is forbidden by regulation promulgated by the state commissioner of health. The Indiana State Board of Health likewise deprecates the use of shields.

The Indiana State Medical Association is sponsoring an inquiry to determine the number of physicians in the state who are drug dispensers and the number who are drug prescribers. Accompanying the inquiry is a question concerning the service rendered by druggists and whether it is satisfactory to physicians and patients alike, or if drug dispensing on the part of the physician gives better results. It is hoped that every physician will render aid in the collection of reliable data on this question. We believe that it would have been interesting to know the reasons of each individual as to the practice he follows in drug dispensing or prescribing.

A reader of The Journal asks us if we are not too pessimistic concerning the final outcome of the medical practitioner. Look about you, brother, and note the various ways in which your activities are being curbed and methods and practices being put into effect to lessen the returns from your work and you too will be pessimistic concerning the eventual outcome. God pity the young man who is just beginning the practice of medicine. The worst feature of this whole matter is that the medical man does so little to help himself, and yet the time is coming when he is going to howl until he is black in the face concerning unfortunate conditions which might have been corrected had he earlier made some move to change the course.

Senator Watson writes us that as a member of the finance committee of the Senate he is in favor of an amendment to the income tax laws which will make it possible for physicians to deduct from income reports the expenses in attending conventions and medical meetings of various kinds. Heretofore, the butter and egg men and the members of the National Horseshoers Association have been permitted to deduct from income their expenses in attending conventions pertaining to their business, but physicians have been denied a corresponding right. As a matter of simple justice the physician should be given as square a deal as butter and egg men or anyone else. We are pleased to know that Senator Watson looks at the matter in that light.

Palmer's million dollar chiropractic school at Davenport, Iowa, is not as popular as it once was. It is said that the students have decreased in number from 3,500 to about three hundred. Palmer says that eighty percent of the chiropractors *"are practicing medicine and not chiropractic."* In view of the fact that chiropractors get into the regular practice of medicine through the back door and without going through the formality of being educated and trained to practice medicine according to scientific methods, why in the name of common sense do the students fall off in number at the Palmer school? There are any number of people who would like to follow a short cut to the practice of medicine, and as we see it, chiropractic furnishes the proper route.

In connection with the various health campaigns that are being conducted at the present time it has been suggested by the secretary of the Indiana State Board of Health that a slogan be adopted, and he offers "Let Your Physician Decide" as one that might be used in Indiana and which if impressed upon the minds and hearts of the public will accomplish more in bringing an understanding of the important relationship which physicians bear to the public than all the preaching, lecturing, newspaper articles and propaganda that can be devised. Inasmuch as this slogan is applicable in preventive medicine and equally applicable to the whole field of medicine and public health, we believe that it is worthy of adoption and should be placed in general use.

Up to date the Indiana State Board of Medical Registration and Examination has licensed about 1,100 drugless healers who have come in under the medical law passed by the last legislature. We predict that every mother's son of them will be giving drugs and practicing medicine according to regular methods within a year. Licensing drugless healers is merely a way of permitting incompetents to practice regular medicine by entrance through the back door. What a sad commentary it is upon our ideas of competency! As we have said before, why have a medical law anyway? The screw loose in our present medical law is that while it licenses drugless healers, it doesn't define the principles of drugless healing, nor to what the practice shall be limited!

The physicians' supply houses continue to put on physical therapy courses, with matriculation fees out of proportion to the value of the courses given. We make this statement in view of the report of one of our readers to the effect that the three courses he attended were not only commercialized and expensive, but emphasis was placed upon the cure-all effect of physical therapy whereas every physician of experience knows that physical therapy has decided limitations. Physical therapy is a valuable adjunct in the practice of medicine, but it should be used with discretion, and under the direction of a physician who knows its limitations. Commercial exploitation of physical therapy will cease when physicians look to medical schools and hospitals for their training.

How much confidence can the public have in the medical profession when a supposedly reputable member of it, acting as a school examiner, overlooks three well-marked cases of diphtheria which eventually result in nine more cases developing and the necessity for closing the school? The same physician announced that antitoxin was in an experimental stage, and he didn't believe in it anyway. We might ask, "Why should our school children be subjected to the opinions of such a physician?" We are aware of the fact that it is difficult to secure competent physicians to take such a thankless job as medical inspector of schools, but some effort should be made by school authorities to have trustworthy medical advice when needed, even though it becomes necessary to pay adequately for the service. Just as long as individuals and aggregations of individuals pursue a penny-wise and pound-foolish policy they can expect to be stung.

A WRITER in one of our exchanges says that he never has been able to see the reason for rendering gratuitous professional services to those who will pay the butcher, garage man, gas station, and movie theater, but who never acquire the moral or financial integrity to include the physician. We quite agree with him that physicians are altogether too apt to grant undeserved charity. We have heard some physicians say that it is their practice to receive the regular fee or nothing. Such a policy is unfair to the physician as well as to the patient, for charity to a patient who can pay something, even though it is not the regular fee, begets dependency and pauperism. Furthermore, it does not encourage honesty and self-respect. Charity where due always will be granted by the reputable physician, but the patient who can afford luxuries does not belong to the class that is entitled to charity in the sense that services are to be gratuitous.

WE are thoroughly disgusted with much of the literature sent out by most of the manufacturers of physical therapy apparatus. The most exaggerated claims are put forth concerning the value of ultra-violet therapy in particular, and the whole thing is placed before the medical profession in a commercial way with emphasis upon the profit to be derived from use. The implied assumption is that a physician will do anything for money and that all he needs is a little encouragement to employ methods that will bring dollars to his pocket even though such methods are questionable and results untrustworthy. A few of the manufacturers are temperate in their recommendations and opinions, but for the most part the physical therapy game is commercialized and misrepresented to the nth degree. The whole proposition needs clarification and perhaps fumigation, so look for something tangible in that line from the Council on Physical Therapy of the A. M. A.

IT is a strange thing that the public is accustomed to paying lawyers exorbitant fees for the most trivial service, and without complaint, and yet that same public has a tendency to begrudge the payment of a trustworthy physician a decent fee for services that not only require more time and skill than that exerted by the lawyer, but which perhaps may mean the saving of a human life. As a sample of the generosity shown a poor devil who was incapacitated for work and "broke," we cite the actual incident where a very reputable lawyer retained a fee of $1,250 for collecting or making a settlement with an insurance company for $6,500 and the settlement was perfected as a result of four letters to the insurance company and two short conferences with the insurance company's attorneys. We have a notion that the same attorney would yell like a stuck pig if he had been charged $1,250 for operation and after attention that saved his life. As one old soliloquizer has said, "Ain't human nature funny?"

NO matter what we may think, politically or otherwise, of Senator A. R. Robinson, of Indiana, every physician ought to sing his praises if he succeeds in having passed in the Senate his amendment to the tax reduction bill to insure to physicians the right to deduct, in the computation of their federal income taxes, traveling expenses incurred in attending meetings of medical organizations. *The Journal of the A. M. A.* says that discrimination against the medical profession in the existing law seems now to be frankly admitted by the commissioner of internal revenue, for in a recent letter he wrote, "The Bureau has not made any general ruling in regard to the deductibility of traveling expenses incurred by business men, tradesmen, laboring men and professional men *other than physicians.*" Senator Robinson has opened a way to obtain for the physicians of the country the justice for which they have so long been clamoring. It remains now for them to support him in his movement.

Our Dumb Animals, a publication issued by various humane societies, pungently criticizes Lindbergh for attending a bull fight in Mexico, and George Eastman for his trip to Africa to hunt big game. We do not approve of bull fights nor torture of any animals, but have no criticism of Lindbergh, who was merely an on-looker at a national sport that had been made an especially gala event in view of his visit. It would have created a great amount of criticism and bad feeling in the minds of the Mexican people had Lindbergh followed the course that the editor of *Our Dumb Animals* thinks he should have followed. As to Eastman, he has a perfect right to engage in legitimate sport without being hauled over the coals by a lot of fanatics who sometimes rise to the point of maudlin sympathy that is uncalled for. However, if some of the reports that we have read are true, Eastman has gone to Africa for the

distinct purpose of securing specimens for furthering the development of natural history.

Occasionally we have an inquiry concerning the standing of the Indianapolis Cancer Hospital, and usually the inquiry is from some physician who desires to protect some of his patients who have been led to take stock in the specious advertising that forms a part of the program of the Indianapolis Cancer Hospital and of every other quack medical institution. It is sufficient to say that every reputable physician will steer clear of any doctor or any institution that indulges in blatant advertising. There are many physicians in Indiana who are trustworthy and can be depended upon to give satisfactory attention to cancer patients, but the Indianapolis Cancer Hospital is not worthy of recognition on the part of physicians or laymen. An expose' of the methods and practices of the institution in question was published in the *Journal of the A. M. A.* September 2, 1922, copy of which may be obtained by writing the Bureau of Investigation of the A. M. A. A leopard does not change its spots, and of course the Indianapolis Cancer Hospital is just as rotten now as it was in 1922.

Since the value of ultraviolet rays in the treatment of diseases such as rickets, some forms of tuberculosis and in certain diseases of the skin has been established, many people are using ultraviolet lamps without medical supervision, Dr. John S. Coulter says in the April *Hygeia.*

Dr. Coulter warns that there are many dangers from the use of the ultraviolet lamp. Among the mechanical dangers he names the risk of electric shock and breaking of the quartz burner. In the case of the carbon arc burner the sparks may burn the patient or cause a fire.

Injuries to the skin are frequently suffered when persons giving themselves treatment at home remain under the light too long. Sunburn, hives, excessive growth of hair are some of the effects that have occurred rather frequently.

Ultraviolet has been found of great value in some forms of tuberculosis. but it can be given only under the guarded supervision of a physician. In pulmonary tuberculosis it is easy to start a smoldering disease to a flaming fire with a small overdose of ultraviolet. Each case must be studied individually by a physician.

As a boy we remember to have gone to the butcher shop and procured liver free of all cost. In fact at that time liver was considered almost worthless as so few people would eat it. With the popularity of liver and bacon for breakfast, liver became a commercial product of importance and added to the income of the butcher even though the price remained low. Within recent months liver has been so advertised as a therapeutic agent that its consumption has largely increased, and with the increased demand has come an increase in the price so that in many markets a pound of liver costs from sixty-five to eighty-five cents, depending upon locality. One packer has said that it is quite likely that the price of liver will increase to such an extent that liver will reach the stage of being called an expensive delicacy. In connection with the increased use of liver as a therapeutic agent it is interesting to note that a large number of liver diet recipes are being published in medical journals and by the lay press. Patients suffering from pernicious anemia may find it profitable to obtain these recipes, and no doubt the *Journal of the A. M. A.* can furnish them from a list that was published.

The editor of The Journal hasn't very much hair on the top of his head. However, he hasn't made much effort to restore the growth that once existed, but has been approached by a number of barbers who have a "positive and sure cure for baldness." Quite recently a waiter in a San Francisco hotel offered a prescription, for the small sum of five dollars, which he guaranteed, under bond he said, would produce a head of hair inside of thirty days. Shortly afterward another barber insisted that within ten days he could show sprouting hair as the direct result of the use of ultraviolet rays generated by a small machine which he had in his shop. Applications should be made every day, and the barber volunteered the information that at two dollars per application the treatment was cheap, inasmuch as the machine was very expensive. We also learned that the machine was in operation a good portion of every day, so the aforesaid barber ought to be able to buy a few business blocks during the next few years. Well, a sucker is born every minute, some minutes more than one is born, and among the latter are the bald-headed men and the pimply-faced women.

Nearly four hundred doctors were delinquent in the payment of medical society dues on March 1st. This does not speak well for the profession of the state, and is a condition that should be corrected. Delinquency is a stigma, but aside from that it may be costly, for no delinquent is entitled to the benefits that come from membership in good standing, not the least of which is medico-legal defense. Some of the members who have been delinquent since February 1st may find that their apathy and indifference to obligations to local medical societies are costly if a malpractice suit is brought for services rendered subsequent to February 1st. Several hundred dollars may be the cost of defense in a malpractice suit, even if the case is won, and that expense is borne by the Indiana State Medical Association if the physician who is sued is a member in good standing at the time the services are rendered for which suit is brought. But aside from this purely mercenary consideration of the matter, the question of the payment of dues ought to be one of principle and self-respect. Medical men generally are

more prompt in the payment of dues than they ever have been in the past, but there still is room for much improvement.

The manufacturers of argyrol have shown their peeve because the Council on Pharmacy and Chemistry of the A. M. A. has declined to admit argyrol to New and Nonofficial Remedies, as the result of the refusal on the part of the manufacturers to have the preparation classified properly. They commence with a misleading statement in which they say that they refused to "misbrand argyrol by labeling it with a vague, meaningless term which encourages substitution." We would like to call attention to the fact that many physicians when using other of the newer silver salts, like silvol, carelessly have permitted the idea to prevail that argyrol was being used and therefore argyrol occasionally gets credit not its due. Furthermore, we doubt if a half-dozen prominent physicians in the United States will be willing to testify that they consider argyrol superior to one or more of the newer silver salts that the Council on Pharmacy and Chemistry of the A. M. A. has declared to be just as efficient therapeutically as argyrol and as agreeable to use. As a side comment, we feel confident that argyrol now will be advertised openly and extensively to the public, with directions for use.

Medical and surgical junketing trips, or tours for pleasure but carrying with them the privilege of obtaining post graduate medical and surgical instruction enroute and at the various places visited, are gaining in popularity as evidenced by the numerous plans for such trips that are advertised in the medical press and through tourist agencies. Unfortunately some of these tours are being commercialized by tourist agencies, and expenses are on the increase, due not only to the addition of deluxe features and numerous side trips, but an increase in the fees paid for the medical instruction. However, in spite of these disadvantages we believe that medical and surgical junketing trips to Europe are deserving of commendation, for together with the recreation and rest that such a trip affords, it combines education with travel, the companionship of agreeable friends, and last but not least, an opportunity to obtain special medical and surgical courses at the fountain head. Furthermore, it is possible to select tours that really are inexpensive and within the means of the average physician. We have no special tour to recommend or suggestions to offer, and the recommendations given are purely of a general character, though based on some experience.

Many physicians long have known that some of the so-called safe hypnotics are habit-forming. Now comes the *Journal of the A. M. A.* with an editorial saying that the so-called safe hypnotics may become menacing to the public welfare, and quotes the work of Phillip Work on "veronal addiction," as published in the *Archives of Neurology and Psychiatry* for February, 1928, who reports one hundred cases of acute poisoning or chronic addiction. It is common knowledge that there are aspirin fiends, and we know of several instances where combinations of aspirin and other sedatives, analgesics and hypnotics have been taken so regularly as to make a real addict of the patient. As has been pointed out by the editorial mentioned, these new drug addictions have brought fresh problems for solution by the innocent physician. The public, too, is entitled to know the facts. As a partial solution of the problem we suggest that physicians should be more cautious in prescribing the newer hypnotics, and especially in letting the patient know what is being prescribed so that there will be less tendency for self-prescribing. As a side issue it would be well to have some means put into effect to prohibit refilling of prescriptions except on the order of a physician.

If anyone doubts that sun-rays or light therapy is popular, all he has to do is visit some of the well-known beaches when the weather is warm. There he will see both men and women with scarcely any clothes on, or at least as few as the law will permit, lying in the sweltering sun from early morning until late in the afternoon. That this practice is productive of great harm in some individuals is evidenced by the extensive burns that often occur through too long exposure at first, and perhaps the posssession of a delicate skin. Not a few of these badly burnt cases wind up in a hospital, and during the past winter the editor of The Journal saw many severe sunburns in those who had been stretched out on the hot sands of Waikiki beach at Honolulu, and within a period of four weeks three of these cases landed in a hospital with one of them reported as being in such serious condition as to threaten life. Many of those more careful were browned so that they looked much like the native Hawaiians and probably felt that the sun therapy had been very beneficial. However, if serious results can come from natural light baths it goes without saying that the artificial sun baths, like those from ultraviolet lamps, can be equally injurious. Light therapy is a good thing when it is used judiciously, but, like every other good thing, it may be abused.

Sometimes it is a risky business to make a prognosis of early fatal termination in a case that may miraculously turn out differently. We are reminded of this by an instance that came to our attention recently. A prominent business man who had suffered some months from a chronic ailment had a sudden turn for the worse and the family physician gave it as his opinion that the patient would die within a few days. In consequence of this opinion the children at college and numerous relatives were summoned. The patient did not die.

but lived for several years afterward, and the aforesaid physician not only came in for marked condemnation by the family and friends but suffered in reputation through his hasty and dogmatic prognosis. How much better it would have been had the attending physician said to the family "unless an unexpected change for the better occurs, the patient probably will die in a few days." Every physician knows that occasionally an apparently rapidly fatal disease will take a rather miraculous change for the better, and while this is the exception rather than the rule yet it is well to take the exception into consideration and qualify the prognosis accordingly. The family and friends of the patient deserve to be protected by the truth, but at the same time the attending physician must protect himself from the charge that he is unduly and unjustifiably dogmatic in his decision.

Congress is now called upon to wrestle with the question of legally recognizing *incompetency* in the practice of medicine, for Senator Copeland has introduced a bill (S3592) which provides that the degrees of doctor of medicine and doctor of osteopathy shall be accorded the same rights and privileges under governmental regulation. If the bill becomes a law the public has absolutely no protection against fraud and incompetency in the treatment of disease. Why have any medical practice acts at all when none of them require evidence of training and education in the diagnosis of disease. Why not let anyone open an office, advertise his professed business of curing disease, permit him to practice any system or no system at all, and collect from the gullible public what he can. It would be no worse than what is proposed by Senator Copeland's bill recently introduced in Congress. It is a strange thing that after establishing such schools of learning as Harvard, Johns-Hopkins, the University of Indiana, and others, where competency in the diagnosis and treatment of disease is taught, legislative bodies should attempt to tell us that competency as taught by those institutions is unnecessary, thus indicating that such institutions are useless and that there is no just reason for their continuance. It seems to us that we once heard the word consistency used and applied, but we are under the impression that we should forget the matter.

After visiting a hospital of the pavilion type containing about seventy segregated lepers, and having opportunity to examine the inmates who exhibited leprosy in its various forms and discussing the leper question with physicians and attendants who have been handling the disease for many years, we are inclined to believe that some of the discussions on leprosy found in books on dermatology need revision. It would seem that leprosy is neither as infectious nor as fatal as we have been led to believe, and recoveries are not uncommon. How infection occurs is not known, but it is thought that rather prolonged and intimate contact is necessary, though such assumption carries with it some exceptions in the case of the attendants who have been caring for lepers for many years and have not contracted the disease. It is generally thought that leprosy is exceedingly rare in the United States, and yet mild types of it probably exist and have not been recognized. Perhaps most people are immune, and it seems to be fairly well established that in certain individuals the disease may continue for a great many years as a comparatively trivial manifestation. At present segregation seems necessary, and so far the best results from treatment occur in those cases that have been given the esters derived from chaulmoogra oil. In fact we saw leper cases that were about to be discharged as a direct result of the beneficial effects of this remedy.

In the January issue of The Journal we suggested that the Indiana State Board of Health could well consider the advisability of providing slips for physicians, to insert in letters or statements to patients, concerning immunization against diphtheria. We now learn that for more than a year the State Board of Health has been using such slips, and that a report concerning the matter appeared in the Monthly Bulletin of the Board, though we did not have the pleasure of seeing it. We offer our apologies to Secretary King for not having been familiar with this advanced movement on the part of our State Board of Health. The slip, as furnished by the Indianapolis office, reads as follows:

DO YOU KNOW THAT

Diphtheria is unnecessary and ALL CHILDREN can be protected from diphtheria FOR LIFE?

HOW—By *toxin-antitoxin.*

WHEN—A good time is now.
The best time is at six months of age.

WHERE—By your own physician.

WHY—To remove for all time the possibility of your child taking diphtheria.

INDIANA STATE BOARD OF HEALTH
Wm. F. King, M.D.
State Health Commissioner

We understand that several thousand of these slips have been mailed to parents, and if we are not mistaken physicians who are interested in helping to carry out a campaign against diphtheria can obtain a supply of the slips from the Board.

Recognizing that traumatic injuries in general have not been cared for by the better qualified in surgery, and that a considerable amount of blame for the situation is due to the practices of insurance carriers and the failure on the part of the better qualified surgeons to interest themselves in this field of activity, the American College of Surgeons is investigating the situation with the idea of doing away with the rank commercialism of industrial service as it exists today and recommending that all hospitals receiving traumatic cases for treatment be required to meet the minimum standard requirements of the American Col-

lege of Surgeons, and that each of these hospitals shall have a committee responsible for the supervision of traumatic surgery. Incidentally, it is asked by the College that the surgeon called upon to treat traumatic cases shall be not only a graduate of scientific medicine in good standing and licensed to practice in his respective state or province but that he shall be competent in the field of traumatic surgery, ethical, and that in the latter connection the practice of division of fees under any guise whatever shall not be followed. This movement is to be brought to the attention of employers of labor as well as insurance carriers to the end that competent and trustworthy service shall be rendered the injured employee, and that the whole field of industrial surgery shall be divorced from the commercialism that now enshrouds it. The movement is one that certainly deserves encouragement and support.

A report of a committee to study the tobacco problem has just been published in book form. *The Journal of the A. M. A.*, January 28, 1928, says that "unfortunately the reaching of helpful conclusions after reading these and other articles is difficult. Presumably the reason is that the facts are difficult to establish. Many variables confuse investigators. A given set of investigations may not apply on another set of investigations. What the world would like to know about tobacco is whether it is harmless, harmful, or beneficial. To answer this question it is necessary to avoid reasoning without reservation, from the analogy of nicotine injections in animals to the effect of tobacco on man. From present available evidence the main conclusions that are justified seem to be the following: The use of tobacco, even in moderate quantities, seems to lower the efficiency of the heart under strain. This may be classed as a harmful effect. Taken moderately, tobacco tends to stabilize responses to sensory stimuli. This may be classed as a beneficial effect. Other effects depend upon individual susceptibility, kind and condition of tobacco, method of taking it, and amount consumed. Even tobacco amblyopia seems not to bear any relation to excessive use of the plant. Until more is known, the only general rule that can be given applies to those who feel ill effects of tobacco. Obviously such persons should be guided by the advise of physicians who have made thorough investigations of their particular cases."

As announced in the program for the meeting of the Physicians Fellowship Club of Chicago for March 30th, we find the following statement: "A man who has been honored by the medical profession went to the Chamber of Commerce of South Chicago with a scheme for the building of an immense charity institution. The physicians of South Chicago were ignored. Five members of the South Chicago branch of the Chicago Medical Society who had enough civic interest to belong to the Chamber of Commerce were consulted in the matter. To their everlasting credit, they saved South Chicago from being advertised as a town of mendicants and beggars."

We quote this to indicate that medical men must take a keener interest in the preservation of the ideals of the profession and the economic standing of physicians in general. Every reputable physician should constitute himself a committee of one to put forth efforts to suppress the specious pleas of welfare workers and reformers who would pauperize and make dependent a large portion of our population, to say nothing of causing a loss of self-respect of many self-supporting people. All of these various welfare schemes require the services of physicians, and in the final analysis the physicians pay a heavy penalty, and the public receives no real profit from the venture. Again we say, medical men should not oppose genuine and deserving welfare work, but it is high time that the medical profession should dictate and control welfare work, insofar as medical service is concerned.

As another sidelight on the swindling games that are practiced upon physicians a correspondent calls our attention to the practice of certain stock brokers in calling up doctors by long distance phone to tell them that if they want to get in on a "killing" on the stock market the time to invest is at the moment. Some suggestions are offered as to the particular stock to buy, but usually the matter is left to the discretion of the doctor with vague hints concerning a rising market. Not only is the whole thing a gamble, with more chances to lose than to win, but aside from this there are some of these stock brokers that are tricky in the matter of options, protecting deposits, and commissions on sales. They always are looking out for themselves. Our correspondent says that he was induced to buy from stock brokers, who called over the long distance telephone, certain bonds that were paying good interest. A little later, desiring to raise some money promptly, he asked the firm to dispose of his bonds, which, of course, brought the market price, and discovered to his dismay that the brokers charged him an extortionate ten percent commission for making the sale. If we may be permitted to offer a word of advice it is that doctors have no business fooling with brokerage houses who deal in stocks on margins, and when it comes to a question of buying any productive stocks or bonds outright, they will be wise if they buy through their own banks. The bond department of any first class bank may be trusted, but it is just as well to be a little skeptical of the majority of brokerage houses.

Dr. E. S. Leach, of Junction City, Kansas, announces that he is about to enter Indiana to introduce his new "filtration method" of treating diseases of the upper respiratory tract. His circular letters speak of the profit to be made by those physicians who employ his method. Presu-

mably those who take up with the new method will have to contribute to the originator. In the circular letter sent out we find this statement, "We are at this time just writing the nose and throat men of middle age, as we find the middle aged men are more forward looking and ready for progress." To our notion this would indicate that the middle-aged men are considered to be the biggest suckers, and probably that is true. At all events, the younger men may consider that they have been complimented. Dr. E. S. Leach's name appears in the last A. M. A. directory as living in Junction City, Kansas, a town of less than eight thousand inhabitants. He is a man sixty years old, graduated from a small and indifferent medical college in St. Joseph, Misouri, in 1894, and was licensed to practice in Junction City, Kansas, in 1916. He is not credited as being a member of any reputable medical society, not even the county medical society of his own county. While he poses as a specialist, he is not rated as such in the A. M. A. directory, nor in the Red Book, the latter seldom if ever omitting the name of any person making the slightest pretenses to a specialty. To those Indiana specialists who have written us concerning this matter permit us to suggest that you look before you leap.

The slogan, "An apple a day keeps the doctor away," was put out by the apple growers' association. No doubt the movement led to greater consumption of apples and of course increased profit to the apple growers. Now the citrus fruit growers, particularly those in California, are carrying on an extensive advertising campaign to get people to consume more grapefruit and oranges. "Cure yourself with oranges and grapefruit juice" is the slogan. What has been started by the California fruit growers is being taken up by the fruit growers of Florida and Texas. A deceiving part of the advertising campaign is the information that practically everyone suffers from acetonuria which citrus fruit will cure. Aside from this, the advertising conveys the idea that a great deal of ill health is caused by acetonuria and that citrus fruits will cure many of the ills of mankind in consequence. There is no question but that fresh fruits and vegetables should form a part of a well-balanced ration, but if we are not mistaken the exaggerated and unproven statements concerning the therapeutic value of citrus fruits, which is being put out by the fruit growers' association, will act as a boomerang. Perhaps someone, seeking notoriety, will say something about the injurious effects of citrus fruits when consumed liberally, and then the jig will be up. As a general proposition truth in advertising pays, and when you deviate from the plain truth you may profit temporarily, but in the end you lose. There is not the slightest scientific evidence to prove that citrus fruits have any specific therapeutic value as a cure for certain diseases.

Look out for beggars and solicitors of every description. This warning is justified in view of the numerous instances in which physicians have been taken in by persons presenting fraudulent claims. The young man or young woman who asks you to subscribe for any of the leading periodicals of the country and then suggests that you pay the subscription direct to him or her is presenting a proposition that should be looked upon with suspicion. Even bonafide solicitors for periodicals, and salesmen for book publishers, oftentimes tell a pathetic story about attempts to raise money for a hospital bill or to pay tuition in college, which stories have no foundation in fact but have a tendency to stimulate generosity on the part of those solicited. One of the most prominent physicians in the state was solicited recently by a young man presenting fraudulent credentials and writes us concerning the matter as follows:

> Editor of The Journal: Within a week a young man whose testimonials bore the name of Ben F. Pelot came to my office to solicit subscriptions to a long list of journals. He said that he had 120 premedical collegiate credit hours from the University of Georgia and that he was earning money now to pay his way through the first year of the medical course. I told him to return in one week and that I proposed to know more about him. I have just learned from the chancellor of the University of Georgia that no such person is or has been a student there. I also learn that no such man has put in an application for medical matriculation at our own university. Doctors may well be cautious in accepting the statements of young solicitors who claim to be medical students.

In the case mentioned, the solicited investigated before he invested, and as we already have pointed out, that is a plan that always should be followed.

One of our correspondents asks for concrete evidence of the enforcement of the medical practice act. We refer this query to the Board of Medical Registration and Examination in the hope that we can have some news items that will show the medical men of Indiana what really is being done to enforce the medical practice act. Incidentally, we desire to say that while the legislature has created a medical practice law, and a Board of Medical Registration and Examination whose duty it is to enforce the law, yet no appropriation has been made to pay the expenses of enforcement. Therefore, we are in the anomalous position of having a medical practice act but with little or no means to make the act effective. Our Board is a splendid one, representative in character, and so far as the regular medical profession is concerned is represented by two of the best men that could be selected for the positions. If there is any inactivity or failure to produce results it is not the fault of the Board but rather lack of machinery to enable the Board to function properly.

We frankly confess that we see no particular

reason for having any medical practice act in Indiana, when we look about us and see how quacks and charlatans are permitted to operate unmolested. No doubt this may be accounted for in a large measure by lack of machinery to enforce the law as it exists and, in all probability, so little assistance from the medical profession is a direct result of the knowledge that convictions are hard to obtain. However, we notice that Indiana is no worse than other states, and California, which used to be so rigid in prohibiting anything but the most competent physicians to practice within its confines, now harbors quacks and incompetents of every shade, color and kind.

A prominent physician of Massachusetts writes us that the original industrial law in Massachusetts delivered the employee, body and soul, to the insurance company, but a determined effort on the part of the physicians resulted in a "freedom of choice" for the employees. It was a bitter political fight inasmuch as the insurance companies are always in politics, and, strangely, the labor organizations appeared to be apathetic, though the movement on foot was almost wholly in the interests of employees.

If we are not mistaken, the present Indiana law reads that the insurance company carrying the employer's liability has the right to dictate who the physician or surgeon shall be in cases of industrial injuries. Whether this right rests originally in the employer or in the insurance carrier is immaterial. The injured employee may at his own discretion employ his own physician, but in so doing he has to assume the expense involved. The law is not satisfactory, in view of the fact that insurance carriers so often dominate the entire situation and prevent just settlement of all claims. Brow-beating of physicians by the insurance adjusters has been common, though with the functioning of the industrial committee of our state association there has been less tendency to impose upon members of the medical profession inasmuch as our committee has been a mediator, or we might say a satisfactory arbitrator, in bringing about just settlement. However, Indiana is in the position of Massachusetts before the latter's law was changed, and it is unfortunate that the physicians of Indiana did not join hands with the labor unions during the last session of the legislature and secure modification of the present industrial law. The industrial committee of our Association may well have this matter in mind for the next session of the legislature.

The Indiana State Board of Health has promulgated some new rules and regulations, one of which is of particular interest to physicians. It reads as follows: "A child born dead at seven months gestation, or over, shall be reported and recorded both as a birth and a death, and a burial permit is required as in the case of a regular death. A child that lives and breathes after birth, no matter how brief the period and regardless of the period of gestation, is a living child and shall be reported and recorded both as a birth and a death. For this purpose a birth shall be considered as complete at the instant of separation of the entire body of the child from the body of the mother. Life shall be considered as being present if the child breathes after birth. All births shall be reported within thirty-six hours after occurrence, upon official birth blanks, by the physician or midwife in attendance, if any, otherwise by the householder. In the event that the child is born illegitimate, the physician or midwife in attendance shall give as name of the father such name as is supplied by the mother or her friends, but he shall not in any degree be responsible for the same. An illegitimate child takes the name of the mother."

The first part of this amendment was adopted to qualify the question as to when should a so-called stillbirth be reported as a birth? It is believed that the definition of a living child, as set forth in the amendment adopted, is in line with the best statistical practice, and should settle the question as to reporting.

Another recently adopted amendment has to do with the transportation of dead bodies by automobile conveyance, and provides that a transportation permit, such as heretofore has been used only when the body is to be transported by railroad or interurban, shall also be required when the body is to be transported outside of the state by automobile conveyance.

Further amendments require the submission of water supply and sewage plans to the State Board of Health for its approval.

DEATHS

Lewis C. Griffith, M.D., of Bowling Green, died February 19th, aged seventy-nine years.

Isaac M. Smith, M.D., of Muncie, died February 11th, aged seventy-seven years. Dr. Smith was graduated from the American Eclectic Medical College, Cincinnati, in 1878.

Robert M. Recobs, M.D., of Tipton, died March 7th, aged sixty-two years. Dr. Recobs was a member of the Tipton County Medical Society, the Indiana State Medical Association and the American Medical Association. He was graduated from the University of Louisville Medical School in 1893.

Noah Webster Clark, M.D., of Rossville, died February 24th, aged fifty-seven years. Dr. Clark was graduated from the Medical College of Indiana, Indianapolis, in 1904. He was a member of the Clinton County Medical Society, the Indiana State Medical Association and the American Medical Association.

Earl A. Rogers, M.D., of Somerset, died February 27th, aged fifty years. Dr. Rogers was a member of the Wabash County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He was graduated from the University of Michigan Medical School at Ann Arbor in 1901.

William W. Tucker, M.D., of Greencastle, died March 16, following an attack of influenza. Dr. Tucker was a member of the Putnam County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He was graduated from the Miami Medical College, Cincinnati, in 1889.

Carl W. Rutledge, M.D., of Indianapolis, died February 17th, aged forty-eight years. Dr. Rutledge had practiced medicine in Indianapolis for twenty-five years. He was graduated from the Medical College of Indiana, at Indianapolis, in 1903. Dr. Rutledge was a member of the Indianapolis Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

John L. Puckett, M.D., of Kokomo, died February 22, aged eighty-one years. Dr. Puckett was graduated from the Medical College of Indiana, Indianapolis, in 1879. He was a member of the Howard County Medical Society, the Indiana State Medical Association and the American Medical Association. He was a veteran of the Civil war. Besides his duties as a practicing physician, Dr. Puckett's activities included the duties of a minister of the gospel and he served as mayor of Kokomo, during which time he also served as city judge.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in The Journal of The Indiana State Medical Association. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

Dr. H. R. Allen, of Indianapolis, has just returned from a trip around the world.

Dr. Maxwell Harbin, of Western Reserve University, presented a paper on "Surgery of the Knee Joint" at the February 10th meeting of the Muncie Academy of Medicine.

Dr. J. A. Sutcliffe, of Connersville, has been made an honorary member of the Indianapolis Medical Society. Dr. Sutcliffe has been a member of the society for almost fifty years.

Dr. Charles H. Mayo addressed a meeting of the Indianapolis Academy of Medicine, March 16th, at the Columbia Club. His subject was "Aids in Reducing Surgical Mortality."

The March meeting of the Madison County Medical Society was held at the Grand Hotel in Anderson on March 20th. Dr. Charles F. Neu, of Indianapolis, presented a paper on "Encephalitis."

Dr. and Mrs. Albert E. Bulson, Jr., of Fort Wayne, recently have returned from a midwinter vacation in the Hawaiian Islands. On the return trip several weeks were spent in southern California.

The Noble County Medical Society and the Noble County Tuberculosis Association held a joint meeting at Kendallville, March 5th. Dr. L. L. Shuler, of the James Whitcomb Riley Hospital, conducted a clinic for crippled children.

At the March 27th meeting of the Indianapolis Medical Society, held at the Athenaeum, Dr. Howard Lilienthal, of New York City, presented a paper on "Surgical Treatment of Pulmonary Tuberculosis." There were 160 attendants at this meeting.

The *Boston Medical and Surgical Journal* has changed its name to *The New England Journal of Medicine*. The Journal recently celebrated its one hundredth anniversary. It includes in its representation the state societies of Vermont, New Hampshire and Massachusetts.

The regular monthly seminar of the Indiana University School of Medicine was held at the medical school building February 24th. The program consisted of presentation of hospital cases and papers on "Capillaries of the Body," "Blastomycotic Infections," and "Occupational Therapy."

Dr. W. T. Lawson, of Danville, and Dr. F. L. Thornburgh, of Middletown, each celebrated the fiftieth anniversary of their entrance into the practice of medicine in March of this year. Dr. Lawson began practice in Danville on March 1st, 1878, and Dr. Thornburgh started in Middletown on March 11th, 1878.

The U. S. Civil Service Commission announces open competitive examination for physiotherapy aide and physiotherapy pupil aide, to be held on or before April 21 and June 23, 1928. Complete information and application blanks may be secured by writing to the United States Civil Service Commission, Washington, D. C.

The American Doctors Clinic and Golf Association will conduct an European tour, in connection with Pratt's European Travel Tours, leaving New York City July 7th and sailing for home from France August sixteenth. Information concerning the tour may be obtained from Dr. J. L.

Smith, Secretary, 2312 North Sawyer Avenue, Chicago.

THE United States Civil Service Commission announces open competitive examinations for trained nurse and trained nurse (psychiatric). Applications must be on file with the Civil Service Commission at Washington, D. C., not later than April 28. Married women will not be appointed to these positions. Full information may be obtained from the United States Civil Service Commission at Washington, D. C.

AN invitation has been extended to American physicians to attend the First International Otorhino-laryngological Congress at Copenhagen July 29 to August 1, 1928. Full information regarding the congress may be obtained by addressing: American Committee for First International Otorhino-laryngological Congress, 25 Broadway, New York. American attendants will sail from New York on July 6th.

A BOOK containing condensed report of a special survey of a number of typical industries in the United States has been published by Johnson & Johnson, New Brunswick, New Jersey. The survey was made to ascertain the methods employed and the service rendered to employees in treatment of injuries following preliminary measures of first aid. The book contains 136 pages and will be sent to any physician who is interested in first aid and medical service in industry upon request.

THE first unit of the forty million dollar medical center in New York will be opened this month after seven years of planning and construction. The official opening day was March 16th, when the new Presbyterian Hospital building at the medical center in New York was opened for inspection. This building is the tallest hospital structure in the world and in it are housed the Presbyterian Hospital, the Sloane Hospital for Women and the Squier Urological Clinic. It has an ultimate bed capacity of 1,177.

DR. SAMUEL E. EARP, of Indianapolis, was honored at the meeting of the Phi Beta Phi medical fraternity held in Indianapolis March 9, when they voted to establish a lectureship fund for the Indiana University School of Medicine in Dr. Earp's name. The northern province of the fraternity, comprising Indiana, Michigan, Illinois, Wisconsin and Kentucky, will support the fund unaided. Also at this meeting Dr. Ernest Rupel, of Indianapolis, was re-elected alumni president of the northern province of the fraternity.

THE Fifth International Medical Congress for Industrial Accidents and Occupational Diseases is definitely announced to be held in Budapest, Hungary, September 2 to 8, 1928. The Travel Study Club of American Physicians, of which Dr. Fred H. Albee of New York City is president, has rearranged its summer trip for 1928 especially to focus upon the Budapest congress. Applications for membership and requests for information should be addressed to Dr. Richard Kovacs, Secretary, 223 East Sixty-eighth St., New York City.

FIVE of the seven surviving members of the class of 1878 of the old Indiana Medical College held a reunion at the Claypool Hotel, Indianapolis, February 28th. The attendants were Dr. H. B. Tanner, of Eastland, Texas; Dr. James H. Taylor, of Indianapolis; Dr. T. B. Plowman, of Georgetown, Illinois; Dr. Amos Carter, of Rockville, Indiana; and Dr. Allen Pierson, of Spencer, Indiana. The five physicians toured the Indiana University School of Medicine, conducted by Dean Charles P. Emerson and had luncheon at the James Whitcomb Riley Hospital for Children.

THE Congress of American Physicians and Surgeons will hold its fourteenth triennial session in Washington, D. C., May 1st and 2nd, 1928, with the Mayflower Hotel as headquarters. The Congress is composed of the members of the following national societies: the American Ophthalmological Society; American Otological Society; American Neurological Association; American Gynecological Society; American Dermatological Association; American Laryngological Association; American Surgical Association; American Climatological and Clinical Association; Association of American Physicians; American Association of Genito-Urinary Surgeons; American Orthopedic Association; American Pediatric Society; American Association of Pathologists and Bacteriologists; American Society of Tropical Medicine; American Association for Thoracic Surgery. All members who register will be sent a copy of the published Transactions of the Congress.

IN addition to the articles already enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Hollister-Stier Laboratories: Alder Pollen Extract-Hollister-Stier; Aspen Pollen Extract-Hollister-Stier; Atriplex Pollen Extract-Hollister-Stier; Awnless Brome Grass Pollen Extract-Hollister-Stier; Blue Bunch Grass Pollen Extract-Hollister-Stier; Box Elder Pollen Extract-Hollister-Stier; Canada Blue Grass Pollen Extract-Hollister-Stier; Cheat Pollen Extract-Hollister-Stier; Common Sagebrush Pollen Extract-Hollister-Stier; Crested Koeleria Pollen Extract-Hollister-Stier; Dandelion Pollen Extract-Hollister-Stier; Eastern Ragweed Pollen Extract-Hollister-Stier; English Plantain Pollen Extract-Hollister-Stier; Giant Poverty Weed Pollen Extract- Hollister-Stier; Kentucky Blue Grass Pollen Extract- Hol-

lister-Stier; Lamb's Quarters Pollen Extract-Hollister-Stier; Mugwort Pollen Extract-Hollister-Stier; Orchard Grass Pollen Extract-Hollister-Stier; Perennial Rye Grass Pollen Extract-Hollister-Stier; Quack Grass Pollen Extract- Hollister-Stier; Red Top Pollen Extract-Hollister-Stier; Redroot Pigweed Pollen Extract-Hollister-Stier; Russian Thistle Pollen Extract-Hollister-Stier; Sandberg's June Grass Pollen Extract-Hollister-Stier; Sheep Sorrel Pollen Extract-Hollister-Stier; Spring Birch Pollen Extract-Hollister-Stier; Timothy Pollen Extract-Hollister-Stier; Velvet Grass Pollen Extract-Hollister-Stier; Western Ragweed Pollen Extract-Hollister-Stier; Willow Pollen Extract-Hollister-Stier.

Maltbie Chemical Co.: Compound Syrup of Calcreose.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

February 20, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman, Murray N. Hadley, M.D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held February 13 read, corrected and approved.

The Bureau read, corrected and approved the fifth article on periodic health examination series to be released Saturday, February 25. This article deals specially with the necessity of early diagnosis of tuberculosis.

Reports were received upon the following medical meetings:

February 7, Cambridge City Kiwanis Club.

February 16, Cass County Medical Society. "Heart." Report not in.

Requests for speakers:

February 27, Jefferson County Medical Society, Madison. Periodic health examination demonstration. Speaker obtained.

March 22, Kiwanis Club, Crawford Hotel, Crawfordsville. Periodic health examination.

There being no further business the meeting was adjourned.

The above minutes were approved in each separate part and as a whole February 27, 1928.

William N. Wishard, M.D.,
Chairman,
Thos. A. Hendricks,
Secretary.

BUREAU OF PUBLICITY

March 1, 1928.

Meeting called to order at 5:00 p. m.

Present: Wm. N. Wishard, M.D., chairman, Murray N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held February 20 read, corrected and approved.

The Bureau read, corrected and approved an article entitled "Basketballitis—a Hoosier Epidemic," prepared for release Friday, March 2.

The Indiana column of notes in the *American Medical Association Journal* came to the attention of the Bureau. The Bureau is supplying a number of these notes to the *American Medical Association Journal* and will appreciate receiving notes from Indiana physicians or medical organizations which might be suitable for this column.

A number of the *Idaho Medical Messenger* published by the Idaho State Medical Association came to the attention of the Bureau. The leading article in this publication is upon the nation-wide campaign for the early diagnosis of tuberculosis. The Bureau of Publicity was especially interested in this article as a publicity campaign for a periodic health examination and early dianosis of tuberculosis has just been completed by the Bureau in conjunction with the Indiana State Tuberculosis Association.

The following letter was received from a member of the Publicity Committee of the Louisiana State Medical Association:

"I am a member of the Publicity Committee of the Louisiana State Medical Association. In reply to a letter which I wrote to Dr. Olin West, our National Secretary, he suggested that I write to you since your state association is very active along publicity lines and is getting results.

"I shall greatly appreciate any information you may give or any suggestion you may offer regarding this important work. If it is not asking too much, I would like very much to have a detailed description of your plans."

The secretary was instructed to answer this letter and give all information possible in regard to the work in Indiana that might aid the physicians in Louisiana in the establishment of a publicity bureau similar to that already established in Indiana.

Reports were received upon the following medical meetings:

February 16, Cass County Medical Society.

February 27, Jefferson County Medical Society. Periodic health examination.

Requests for speakers were received as follows:

March 5, Rush County Medical Society. "Tuberculosis." Speaker obtained to fill this engagement.

March 6, Jackson Township School, Rush County "Diphtheria and Scarlet Fever Prevention for Children." Speaker obtained to fill this engagement.

March 13, Knox County Medical Society. Speaker not yet obtained.

March 13, Center Township School, Rush County. "Diphtheria and Scarlet Fever Prevention for Children." Speaker obtained.

March 22, Kiwanis Club, Crawfordsville. Periodic health examination talk. Speaker obtained to fill engagement.

Letter was received by the Bureau from representative of the Indiana State Medical Association to the annual meeting of the State Tuberculosis Association which was held at Gary, February 15 and 16. His letter stated that a report upon this meeting would be made in the near future.

The following letter was received from the secretary of the West Virginia Medical Association:

"Several months ago you were kind enough to send me all of the available literature on your luncheon club publicity plan, and I am glad to report that we are just getting the same thing organized in West Virginia. Now, I wonder if it would be possible for me to get a copy of some of the talks that have been made by your doctors. If you have anything along this line that you have worked out, I certainly would be glad to look it over."

The secretary was instructed to obtain copies of these talks wherever possible.

There being no further business the meeting was adjourned.

The foregoing minutes were approved in each separate part and as a whole March 5, 1928.

William N. Wishard, M.D.,
Chairman,
Thos. A. Hendricks,
Secretary.

BUREAU OF PUBLICITY

March 5, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman, J. A.

MacDonald, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held March 1 read, corrected and approved.

The following bills were approved for payment:

A. B. Dick Company	$ 4.00
Central Press Clipping Service	5.00
A. B. Dick Company	4.00
Total	$13.00

The Bureau of Publicity read, corrected and approved the article, "Spring Tonics," prepared for release Saturday, March 10, 1928.

Letter was received giving the program of the Indiana University School of Medicine Post-graduate course upon mental and nervous diseases. This course is to be given during March and April at Seymour, Indiana.

The following reports of medical meetings were received:

February 16, Cass County Medical Society, Logansport. Subject, "Heart."

February 27, Jefferson County Medical Society. Periodic Health Examination.

The following meetings are to be held:

March 5, Rush County Medical Society. Subject, "Tuberculosis."

March 6, Jackson Township School. "Diphtheria and Scarlet Fever Prevention for Children."

March 8, Pittsboro Parent-Teachers' Association.

March 13, Knox County Medical Society.

March 13, Center Township, Rush County. Subject, "Diphtheria or Scarlet Fever Prevention for Children."

March 22, Kiwanis Club, Crawfordsville. Periodic Health Examination. Speaker obtained to fill this engagement.

There being no further business the meeting was adjourned.

The foregoing minutes were approved in each separate part and as a whole, March 19, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

March 19, 1928.

Meeting called to order at 4:45 p. m.

Present: Murray N. Hadley, M.D., J. A. MacDonald, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held March 5 read, corrected and approved.

The release, "Mal de March—The Common Cold," was read, corrected and approved for publication Saturday, March 24.

The following reports on medical meetings were received:

March 5, Rush County Medical Society. Subject, "Tuberculosis."

March 6, Jackson Township, Rush County. Subject, "Diphtheria and Scarlet Fever Prevention for Children."

March 8, Pittsboro. Parent-Teachers' Association. Subject, "Diphtheria and Scarlet Fever Prevention for Children."

No reports received as yet on the following three meetings:

March 13, Vincennes. Knox County Medical Society.

March 13, Center Township, Rush County. Parent-Teachers' Association. Subject, "Diphtheria and Scarlet Fever Prevention."

March 13, Rotary Club, Madison, Ind.

Meetings to be held:

March 22, Kiwanis Club at Crawfordsville. Subject, "Periodic Health Examinations."

The report of the representative of the Indiana State Medical Association who attended the meeting of the Indiana Tuberculosis Association at Gary, February 15 and 16.

This report is to be considered in detail at the next meeting of the Bureau.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole March 26, 1928.

WM. N. WISHARD, M.D.,
Chairman,
THOS. A. HENDRICKS,
Secretary.

MINUTES OF THE MEETING OF THE COMMITTEE ON SECRETARIES' CONFERENCE

Meeting called to order at 12:15, Indianapolis Athletic Club, Indianapolis, Indiana.

Roll call showed the following members present: J. C. Burkle, M.D., Lafayette, chairman, Tippecanoe county; E. M. Shanklin, M.D., Hammond, Lake County; C. A. Stayton, M.D., Indianapolis, Marion County; Harry P. Ross, M.D., Richmond, Wayne-Union County.

Although invited, the following were not present: Thomas R. Owens, M.D., Delaware-Blackford County; A. M. Mitchell, M.D., Terre Haute, Vigo County; Geo. R. Daniels, M.D., Marion, President, Indiana State Medical Association.

The following arrangements were made for the annual secretaries' conference to be held at Indianapolis, April 26, 1928:

Time—6. p. m., April 26 (dinner meeting).

Place—Lincoln Room, fourteenth floor, Lincoln Hotel.

Type of Meeting—Entire meeting to be given over to general round table discussion with leaders selected to talk upon special topics.

PROGRAM FOR MEETING:

I. Call to order. Opening statement by J. C. Burkle, M.D., Chairman.

II. General Round Table Discussion:

a. *County Society Programs,* 7 to 7:30 p. m. Material, type of programs, etc. Discussion—leaders, J. C. Burkle, M.D., Robert G. Moore, M.D.

b. *Membership Problems,* 7:30 to 8 p. m. Collection of dues, solicitation of members, relative value of telephone and postcards in getting word to members. Discussion leaders, Thomas R. Owens, M.D., Delaware-Blackford County; A. M. Mitchell, M.D., Vigo County.

c. *Meetings,* 8 to 8:30 p. m. Relative value of dinner meeting, joint meetings with other professional groups such as dentists, lawyers, etc. Discussion leaders, Harry F. Ross, M.D., Wayne-Union County, and W. T. Lawson, M.D., Hendricks County.

d. *Economics,* Fees for industrial cases—medical witness fees, expert testimony, etc. 8:30 to 9 p. m. Discussion leader, E. M. Shanklin, Hammond, Lake County.

e. *Social Activities of County Societies.* Functions, dinners, mixed meetings, Women's Auxiliary, 9 to 9:30 p. m. Discussion leaders, C. A. Stayton, M.D., Marion County; M. B. Catlett, M.D., Fort Wayne.

MADISON COUNTY MEDICAL SOCIETY

The March meeting of the Madison County Medical Society was held in Anderson on Tuesday evening, March 20th. The guest of the evening was Dr. Charles F. Neu, of Indianapolis, who discussed one of those all too frequent brain infections, encephalitis. Before the late scourge of influenza this condition was a clinical rarity, but since then it has been reported from so many localities that scarcely any community of any size has escaped. Dr. Neu discussed the prevention and treatment of the disease and the recignition of some of the unusual late after-effects which may not develop for many months after an apparently complete recovery.

Respectfully submitted,
M. A. AUSTIN, M.D., Secretary.

INDIANA TUBERCULOSIS ASSOCIATION

March 15, 1928.

Approximately two hundred persons attended the annual meeting of the Indiana Tuberculosis Association, which met at Gary, February 15 and 16, 1928.

The two-day session was devoted for the most part to a discussion of topics relating to the tuberculosis campaign and to health in general. The outstanding addresses were made by Dr. H. E. Kleinschmidt, Medical Field Secretary of the National Tuberculosis Association, and Dr. Esmond R. Long, of the University of Chicago.

Dr. Kleinschmidt spoke on the relationship of the local associations to the national movement, stressing particularly a closer cooperation of the local associations with the medical profession. He discussed the early diagnosis campaign, putting particular emphasis on the important part the medical profession plays in this campaign. He also showed the motion picture, "The Doctor Decides," a film explaining the technique of diagnosis.

Dr. Esmond R. Long addressed the meeting along the scientific basis of the tuberculosis program. He pointed out that although a great deal was known about tuberculosis, any program for its eradication must include research as one of its important features, the two major problems faced being, first, the fact that the severity of the first infection varies enormously in different individuals, even when environmental conditions, as well as the great apparent resistance of those who have recovered from their first infection, to subsequent infection by the germ of tuberculosis.

All research directed toward the elucidation of any of the factors operating in these two types of immunity is as much a part of the campaign against tuberculosis as the actual utilization of present knowledge.

Other papers on different phases of tuberculosis were: "Activating Factors in Tuberculosis," by Dr. C. V. Davisson, of Lafayette; "Childhood Tuberculosis," by Dr. Martha Anderson, Healthwin Sanatorium, South Bend; "Post Sanatorium Supervision," by Dr. H. A. Hatch, Sunnyside Sanatorium, Indianapolis; "Heart Disease in Relation to Pulmonary Tuberculosis," by Dr. R. A. Solomon, Indianapolis; "The Use of Bromipin in the Diagnosis of Tuberculosis," by Dr. J. O. Parramore, Lake County Tuberculosis Sanatorium, Crown Point.

Papers were also given by nurses and lay-workers, telling of the educational campaign being carried on and the manner of approach to the individual and public in general.

Dr. J. E. Gibson, Federal Inspector for Tuberculosis Eradication, told of the results of the bovine tuberculosis campaign.

Among the resolutions adopted by the association, the following were of interest to the medical association:

"WHEREAS, bovine tuberculosis is a great menace to both human and animal life; BE IT RESOLVED, that this association recognizes the importance of the eradication of bovine tuberculosis, and heartily endorses the work being done by the state and federal officials and congratulates those engaged in the work on the success so far attained. We urge the constituted authorities in all counties, where appropriations have not yet been made, to see to it that funds are made available to aid in carrying forward this very important work."

"WHEREAS, in this state there are many counties in which there has been but little or no attention given to the testing of cattle for bovine tuberculosis, and that such are a menace to human life, BE IT RESOLVED that we vigorously push our efforts in disseminating the knowledge of this menace to life, and for the eradication of bovine tuberculosis."

"WHEREAS, in youth, teachings are most firmly and effectually impressed on the mind and become a part of life's thought and action, and that health is most vital to happiness and prosperity, BE IT RESOLVED that the teaching of health be given greater consideration in our school program."

"WHEREAS, tuberculosis and public health and welfare organizations have contributed most successfully in the support of campaigns for conserving the health of people, and WHEREAS good health is the most vital basis of public wealth, and WHEREAS the Indiana Tuberculosis Association has wrought efficiently in contributing to public health and welfare, and WHEREAS there is good reason for intensifying efforts to secure more hospital beds for indigents who are suffering and will suffer from tuberculosis and WHEREAS there is a great need for at least one thousand more sanatorium beds, therefore BE IT RESOLVED that this organization pledge energetic support to a campaign for an appropriation by the 1929 general assembly to provide beds for at least two hundred more patients at the Indiana State Sanatorium. Be it FURTHER RESOLVED that we recommend that a commission be provided for by the Legislature, and an appropriation made for securing a location for another State Sanatorium in the southern part of the state."

The officers elected are as follows:

President—Dr. James H. Stygall, Indianapolis.
First Vice-President—Dr. H. S. Hatch, Indianapolis.
Second Vice-President—William Hice, Terre Haute.
Secretary—Mrs. James P. Wason, Delphi.
Treasurer—Dr. Alfred Henry, Indianapolis.

Respectfully submitted,

J. O. PARRAMORE, M.D.,
Representative of the Indiana
State Medical Association.

INDIANAPOLIS MEDICAL SOCIETY

On March 6th, the program consisted of a motion picture, "The Doctor Decides", sponsored by the Marion County Tuberculosis Association as a part of the campaign of the National Tuberculosis Association for the early diagnosis of tuberculosis. Discussants on this program were: Dr. Murray A. Auerbach, "The Tuberculosis Problem of the State:" Dr. Alfred Henry, "The Clinical Problems of Early Tuberculosis;" Dr. Howard Hatch (Sunnyside Sanitarium), "Early Diagnosis and Sanitarium Treatment;" Dr. William McQueen (Sunnyside Sanitarium), "Ear Diagnosis as Shown by the X-ray;" Dr. E. M. Amos, "The Development of the National Tuberculosis Work." Attendance at this meeting was 100.

At the March 13th meeting a clinical program was held with presentation of cases, at the Indianapolis City hospital. This was a joint meeting with the staff of the hospital. The Society endorsed a complete study of the hospital facilities in Indianapolis, to be made by Dr. William H. Walsh, and sponsored by the Indianapolis Foundation. Dr. Carter, president of the Society, appointed a committee to co-operate with Dr. Walsh in making this survey. The committee was named as follows: Dr. William A. Doeppers, chairman; Dr. John Cunningham, Dr. H. O. Mertz, Dr. W. D. Gatch, D. O. K. McKittrick. The scientific program was presented by the staff. Cases and papers were presented by Drs. M. Masters, H. Mettel, W. C. Service, Ed Kiser, Zarick, H. Beckman and J. T. C. MacCallum.

On March 20th the meeting was held at the Athenaeum, at 8:15 p. m. On recommendation of the Council a motion was made by Dr. Cregor and seconded by Dr. Emerson and passed by the Society to make Dr. J. A. Sutcliffe an honorary member. Dr. Sutcliffe has been a member of the society for more than fifty years. He is Emeritus professor of Genito-Urinary Surgery at Indiana University.

Dr. E. M. Shanklin, of Hammond, spoke on the problems and needs of the Indiana State Board of Medical Registration and Examination. He stressed the need for additional finances to carry on the work of the board. Mr. Walter Shead, Indianapolis News reporter, told of his experiences as a student in the school of drugless healing. It was on information furnished by him that the State Board of Medical Registration was able to prosecute the head of this school for operating a diploma mill.

The meeting of March 27th was held at the Athenaeum. Dr. Howard Lilenthal, chief consulting surgeon, Mt. Sinai hospital, New York City, spoke on the "Surgical Treatment of Pulmonary Tuberculosis." Dr. Lilienthal stressed the fact that surgery in cases of advanced tuberculosis, should only be resorted to after all forms of medical treatment, including pneumo-thorax, have been tried without results.

Respectfully submitted,
Chester A. Stayton, Secretary.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books received since March 1, 1928:

Local Anesthesia. By Geza de Takats, M.D., asst. professor of surgery, Northwestern University School of Medicine, Chicago. Introduction by Allen B. Kanavel, M.D. 221 pages, 117 illustrations. Cloth. Price, $4.00. Philadelphia and London: W. B. Saunders Company, 1928.

Pharmacotherapeutics. By Solomon Solis-Cohen, M.D., and Thomas Stotesbury Githens, M.D. Octavo of 2,010 pages. Exhaustive presentation of pharmacology, materia medica and therapeutics. New York and London: D. Appleton & Company, 1928.

Surgical Clinics of North America. Lahey clinic number—February, 1928. (The Surgical Clinics of North America are issued serially, one number every other month.) Volume 8, Number 1. 210 pages with 74 illustrations. Per clinic year (February, 1928, to December, 1928), paper, $12.00; cloth, $16.00 net. Philadelphia and London, W. B. Saunders Company, 1928.

Treatment of Disease in Infants and Children. By Hans Kleinschmidt, M.D., Professor of Pediatrics, University of Hamburg; and authorized translation of the fifth German edition with additions by Harry M. Greenwald, M.D., attending pediatrician to the United Israel Zion Hosp., Brooklyn. 358 pages. Cloth, price $5.00 Philadelphia: P. Blakiston's Son & Company, 1928.

The Springtime of Physic. By Laurance D. Redway, M.D., attending ophthalmologist, Northern Westchester Hospital, Mount Kisco, New York. An outline of medicine and surgery. 68 pages. Cloth, price $2.00. International Journal of Surgery Co., New York, 1928.

Aluminum Compounds in Food. By Ernest Ellsworth Smith, Ph.D., M.D. 378 pages. Cloth, price $7.00. New York: Paul B. Hoeber, Inc., 1928.

Mechanics of the Digestive Tract. By Walter C. Alvarez, M.D., Associate Professor of Medicine, University of Minnesota (Mayo Foundation). Second edition. 446 pages with 100 illustrations. Cloth. New York, Paul B. Hoeber, Inc., 1928.

Asthma, Its Diagnosis and Treatment. By William S. Thomas, M.D., Associate Attending Physician in Immunology, St. Luke's Hospital, New York. 280 pages with 26 illustrations, some in colors. Cloth. New York, Paul B. Hoeber, Inc., 1928.

Brain and Mind, or the Nervous System of Man. By R. J. A. Berry, M.D., F.R.C.S., F.R.S., Dean of Faculty of Medicine and Professor of Anatomy in the University of Melbourne, etc. 608 pages, illustrated. Cloth. Price $8.00 New York: The Macmillan Company, 1928.

Practical Therapeutics. By Hobart Amory Hare, B.Sc., M.D., Ll.D., Professor of Therapeutics, Materia Medica and Diagnosis in the Jefferson Medical College of Philadelphia, etc. Twentieth edition, enlarged, thoroughly revised and largely rewritten. Illustrated. 1094 pages. Lea & Febiger, Philadelphia, 1927. Cloth. Price $7.50.

Few books attain the popularity that has been accorded Hare's Practical Therapeutics, now in its twentieth edition. While the new edition represents a revision, with additional knowledge concerning old remedies and methods, yet the author has included many new subjects as well as many new ideas that will prove useful to the practitioner of medicine. He says that not many new remedies have been proved of value since the nineteenth edition appeared, but that an immense amount of useful information in regard to relatively old and new ones has been accumulated and has been utilized. Thus it has developed that none of the substitutes for arsphenamine are as useful as the original drug, although the substitutes may possess great value for individual cases. The status of bismuth as a remedy in the later stages of syphilis has become assured, and detailed information is given as to the value of the newer bismuth compounds and the methods of their administration. So, too, as to tryparsamide. Ethylene has developed into a popular anesthetic, and novarsurol has proved of definite value in suitable cases of cardiac dropsy, particularly if it is associated with large doses of ammonium chloride. New drugs, such as metaphen, an antiseptic, ephedrin used as a vasoconstrictor, isasen, a new laxative, and pollen pastes in diagnosis, are described. The article on the various serums has been revised, and new sera such as antiscarlatinal and antimeasles serum are discussed. As in the past, Hare's Practical Therapeutics will stand out prominently as a leading textbook and the book is thoroughly commended.

Treatment of Diseases in Infants and Children. By Hans Kleinschmidt, M.D., Professor of Pediatrics, University of Hamburg; translated from the Fifth German Edition with additions by Harry M. Greenwald, M.D., attending pediatrician to the United Israel Zion Hospital, Brooklyn. Cloth. Price $5.00. P. Blakiston's Son & Company, Philadelphia, 1928.

This book deals purely with treatment, and discusses methods and drugs that the author has found of value in his experiences. The work is a translation of a book that had its origin in Czerny's clinic in Berlin, but it was so favorably received that it has been published in five editions since 1918. It also has been translated into Russian and Portuguese languages. The author confines himself to those therapeutic measures in the field of pediatrics which are strongly indicated and which really appear necessary for successful treatment. Dietetics and physical methods are given first importance in the treatment of diseases of children. Medicinal treatment is only of secondary importance. The subject of dietetics is considered of sufficient importance to be discussed at great length. The dosage of each drug is said by the author to depend on the individual patient, though he gives the maximum and minimum doses according to age in order to facilitate administration. All in all, the book will be a welcome addition to textbooks and works of reference found in the libraries of American physicians and ought to prove of very practical value.

Local Anesthesia. By Geza De Takats, M.D., Asst. Professor of Surgery, Northwestern University, School of Medicine, Chicago. Introduction by Allen B. Kanavel, M.D., Professor of Surgery, Northwestern University, School of Medicine. 221 pages with 117 illustrations. Cloth. $4.00. Philadelphia and London: W. B. Saunders Company, 1928.

To quote the foreword, "No one would suggest that local anesthesia should supplant general anesthesia in all branches of surgery, but that its application should be more general than it is at present no one will gainsay. Conservatism is justifiable, but not a conservatism that does not take account of a method that is effective in operative surgery and attended by fewer complications, and by a lower mortality rate, than general anesthesia."

This book is a didactic attempt to present methods that have proved to be safe and acceptable. Therefore, it is offered as a guide, and the author points out under what

circumstances local anesthesia may be used to the best advantage, to indicate the most effective method of its administration, and to suggest how complications may be avoided. Much has been written concerning the subject of local anesthesia, and we have mentioned in THE JOURNAL several comprehensive works, but this little volume has the advantage of being concise, well illustrated, and thoroughly trustworthy.

EMERGENCIES OF A GENERAL PRACTICE. By the late Nathan Clark Morse, A.B., M.D., F.A.C.S. Revised and rewritten by Amos Watson Colcord, M.D., Surgeon, Carnegie Steel Company, Pennsylvania Railroad System, etc. Second edition. 542 pages. Illustrated. C. V. Mosby Company, St. Louis, 1927. Cloth. Price $10.

This book has been written for a general practitioner and on the presumption that he can make himself an all-round specialist for emergencies in a general practice. The original author (first edition) based his book upon forty years in an emergency practice, and it was his idea to consider the common, unheralded, everyday accidents or emergencies that may and do arise to confront the general practitioner at a time when least expected. The author who has revised and rewritten the work for a second edition very frankly says that one cannot but feel that the general practitioner is sending too much work to the specialist and that the good old family doctor is passing. He then utters a very trite saying when he says that the "remedy is in learning to do many things better." While he advocates broadening knowledge and skill, he at the same time urges the general physician to know his own limitations and draw a very distinct line between the various things that he does well and those that he does *not* do well. A question he always should ask himself is, "Can I do this work, or is a better man available?" Furthermore, if he is to attempt work that ordinarily would fall in the domain of the specialist, he must be prepared to do that work in a satisfactory way, and this means not only equipment but knowledge and experience of how to do it. The book really is a very practical and trustworthy one in all of its teachings and should be of great aid to the physician who is called upon to think quickly and act with rapidity and good judgment. There are a number of splendid illustrations to elucidate the text.

ASTHMA. By William S. Thomas, M.D., Associated Attending Physician in Immunology, St. Luke's Hospital, New York. Twenty illustrations in black and white and six in color. 280 pages. Cloth. New York: Paul B. Hoeber, 1928.

Much has been written concerning the etiology and treatment of asthma, but up to the present time the whole subject has been clouded by confusion and contradictory opinions. The writer of this book is a specialist in immunology, and while he admits that there is great variance in the fundamental ideas of the nature of allergy, yet the subject has been developed to that point where we are justified in looking forward with much encouragement concerning results. Improved results in the treatment of asthma has been made possible by means of the diagnostic aid of specific skin reactions to protein and to vaccine. The author says that the intelligent interpretation of these dermal phenomena has made it possible for asthma patients to obtain material and permanent relief, whereas a few years ago the best that could be hoped for was temporary palliation of their sufferings. However, it is necessary to follow a very definite technique in making protein skin tests and in interpreting the results. Desensitization also is a subject that requires careful attention together with the technique of employing autogenous and stock vaccine. For intractable asthma, the author believes that it is permissible to teach the patient to administer epinephrin subcutaneously himself. It is seldom, however, that the ephedrin given by mouth is not preferable to epinephrin used hypodermically in the palliative treatment of asthmatic attacks. In fact, the author believes, as a result of the extended use of ephedrin in asthmatic and hay-fever patients, that ephedrin is a remarkably efficient drug, and he now uses it almost exclusively instead of epinephrin. The book is exceedingly interesting in view of the fact that it discusses practically all phases of the subject of asthma, including its causes and the various procedures used in the past for its relief. Pollen asthma, which takes in hay fever, also comes in for comprehensive attention. Quite a number of illustrations, some of them in color, help to elucidate the text, and all in all we feel that it is the best book on asthma that has been published.

DISEASES OF THE SKIN. By Henry H. Hazen, A.M., M.D., Professor of Dermatology in the Medical Department of Georgetown University; Professor of Dermatology in the Medical Department of Howard University, etc. Third edition. 248 illustrations. Cloth. Price $10. St. Louis: C. V. Mosby Company, 1927.

This is the third edition of a practical work for the student and general practitioner. A number of very radical changes have been made, in view of the close tendency to classify diseases as to etiology. The term "eczema" has been omitted, and anaphylactic dermatitis has received a consideration not given it in earlier editions. The subject of treatment has received modification to bring it up to present day opinions, and what previously has been said concerning physical therapy apparatus has been revised. Most important of all is the fact that the author has devoted particular attention to the common diseases and wasted no time in the discussion of rare conditions. The book, therefore, should prove particularly valuable to students and practitioners who want something concise and practical, or a happy medium between the voluminous and comprehensive treatises and the student's compend.

BLOOD-PRESSURE. By George William Norris, A.B., M.D., Professor of Clinical Medicine in the University of Pennsylvania; and Henry Cuthbert Bazett, M.D., B.Ch. (Oxon.), F.R.C.S. (Eng.), Professor of Physiology in the University of Pennsylvania; and Thomas M. McMillan, A.B., M.D., Assistant Physician to the Pennsylvania Hospital, etc. Fourth edition, thoroughly revised. Illustrated. Cloth. Price $4.50. Philadelphia: Lea & Febiger, 1927.

This is the fourth edition of a well-known and popular book. It presents no marked changes from previous editions, but that in no way minimizes its value, for it represents the subject in a most practical way. The book represents present-day opinions and is worthy of commendation.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

LIVER EXTRACT NO. 343.—A water-soluble, nitrogenous, non-protein fraction obtained from fresh mammalian liver, manufactured under direction of the Committee on Pernicious Anemia of the Harvard Medical School. It is supplied in vials containing an amount of powdered extract (3 to 4 gm.) representing 100 gm. of fresh liver. Liver Extract No. 343 is used in the treatment of pernicious anemia. Only preliminary observations have been made concerning its value in conditions other than pernicious anemia; apparently it is of value in some other types of anemia, but definitely seems to be of little or no value in many cases of ordinary secondary anemia. Liver Extract No. 343 is administered orally. Eli Lilly & Co., Indianapolis. (*Jour. A. M. A.*, February 4, 1928, p. 385).

COMPOUND SYRUP OF CALCREOSE.—A syrup containing in 100 cc. calcreose solution (New and Nonofficial Remedies, 1927, p. 123) 33.3 cc.; alcohol, 5 cc.; extractives from wild cherry, 4 gm. (20 grains per fluidounce); chloroform, 0.6 cc. (3 minims per fluidounce);

peppermint and other aromatic drugs. Maltbie Chemical Co., Newark, N. J.

Anterior Pituitary Desiccated-Lederle.—The anterior lobe of the pituitary gland of cattle, dried and powdered, without the addition of preservative or diluent. For a discussion of the actions, uses and dosage see Pituitary Gland, New and Nonofficial Remedies, 1927, p. 285. The product is marketed in the form of tablets containing 2 and 5 grains, respectively. Lederle Antitoxin Laboratories, New York. (*Jour. A. M. A.*, February 11, 1928, p. 463).

Posterior Pituitary Desiccated - Lederle. — The posterior lobe of the pituitary gland of cattle, extracted with acetone, dried and powdered. For a discussion of the actions, uses and dosage see Pituitary Gland, New and Nonofficial Remedies, 1927, p. 285. The product is marketed in the form of tablets containing 1/10 grain. Lederle Antitoxin Laboratories, New York.

Whole Pituitary Dessicated-Lederle.—The pituitary gland of cattle, including the infundibulum and the anterior and posterior lobes, dried and powdered, without the addition of preservative or diluent. For a discussion of the actions, uses and dosage see Pituitary Gland, New and Nonofficial Remedies, 1927, p. 285. The product is marketed in the form of tablets containing 1 and 3 grains, respectively. Lederle Antitoxin Laboratories, New York.—(*Jour. A. M. A.*, February 18, 1928, p. 545).

PROPAGANDA FOR REFORM

Dietary Deficiencies and Infection.—A study has been made attempting to correlate the production of rickets with the susceptibility to tuberculosis. In the white rat, rickets may be produced with comparative ease. On the other hand, this animal is highly resistant to tuberculosis when the organisms are given subcutaneously. Young rats were fed on rations presumably adequate with the exception of calcium and the antirachitic factor. Rickets regularly appeared, more readily in cloudy weather than in bright. In the group of these animals injected with tuberculosis organisms the disease could be demonstrated. The series given the defective ration alone developed rickets but no tuberculosis, while doses of the infecting organisms many times larger than those used in the rachitic group failed to induce tuberculous lesions in a number of rats given an adequate ration. Similar results were obtained when the experimental ration lacked only vitamin D for several generations. Rickets was produced and with it a susceptibility to tuberculosis.—(*Jour. A. M. A.*, February 4, 1928, p. 386).

Bathroom Heater as a "Patent Medicine."—Electric heaters, dignified by the name of infra-red generators and adorned with enamel and nickel, are being sold to the public at high prices as potent therapeutic agencies. The book of uses which always accompanies a bathroom heater when it is sold as a therapeutic agent, usually appears to be the work of one whose chief qualification was that he had access to a medical dictionary. True, these lamps generate infra-red rays, but so does a steam radiator or any other hot body.—(*Jour. A. M. A.*, February 4, 1928, p. 388).

Abramsism Abroad.—The fantastic hokum of Albert Abrams is practically a dead issue in the United States. It has been relegated in this country to obvious fakers, some osteopaths, and the occasional physician who suffers from an itching palm or a lack of scientific balance. The Abrams fantastic hokum is now deluding the credulous in England, Canada and France. In Canada it has no support from the more responsible element of the medical profession. In France, the Abrams nonsense seems to be mainly boosted by one Regnault. It is in England, however, that the E. R. A. has taken on its most amusing, or should we say its most tragic, aspect. The chief exponent of the Abrams cult in the British Isles is Sir James Barr, who was once president of the British Medical Association. Sir James seems to have swallowed Abrams' theories hook, line and sinker.—(*Jour. A. M. A.*, February 4, 1928, p. 401).

Sanarthrit and Telatuten Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that Sanarthrit and Telatuten are products of Luitpold-Werk, Munich, Germany, distributed in the United States by East Brook, Inc., New York, claimed to be tissue preparations which owe their origin to Professor Ernst Heilner of Munich. Sanarthrit is proposed for intravenous use as a "causal therapy of all forms of chronic arthritis." It is claimed to be "a specific substance of protein nature; the definite chemical composition is not yet cleared up;" it is "made from animal cartilaginous tissue and purified." The Council found Sanarthrit unacceptable for New and Nonofficial Remedies because the statement of its composition is vague and indefinite; because evidence is not offered to show that its composition is uniform; because it is marketed under a therapeutically suggestive, proprietary name and because the claims for its value are not supported by acceptable clinical evidence and are, therefore, unwarranted. According to the information furnished the Council by the Luitpold-Werk, Telatuten is stated to be "a specific substance of protein nature; the definite composition is not yet cleared up" and it is "made from the entire blood-vessel wall (intima, media, adventitia) of slaughtered animals, and purified." Telatuten is proposed as a "causal treatment of arteriosclerosis." The Council found Telatuten unacceptable for New and Nonofficial Remedies because its composition is indefinite and no evidence is offered to show that its uniformity is controlled; because it is marketed under a therapeutically suggestive, proprietary name; and because there is no acceptable evidence for its therapeutic value and efficacy, the claims made for its use being, therefore, unwarranted.—(*Jour. A. M. A.*, February 11, 1928, p. 463).

Asthma-Sera.—This is another iodide-containing asthma and hay fever nostrum. The statement "Asthma-Sera Ends Asthma and Hay Fever Forever" appears on the stationery sent out by the R. M. B. Laboratories, Seattle, Washington. It does not appear on the trade packages which are subject to the control of the federal authorities which enforce the Federal Food and Drugs Act. Four bottles of Asthma-Sera "is considered a full treatment;" price, $10.50. However, the purchaser of four bottles is told that, if any symptoms of asthma remain when the first half of the fourth is finished, he "should order two more bottles of Asthma-Sera *immediately.*" The A. M. A. Chemical Laboratory analyzed Asthma-Sera and reports that it is essentially a solution containing 8.8 percent strontium iodide, 0.43 percent sodium iodide, and an emodin-bearing (laxative) drug. That iodides will be effective in certain forms of asthma is well known to every physician. Strontium iodide has no advantage over sodium or potassium iodide.—(*Jour. A. M. A.*, February 11, 1928, p. 480).

Joy Beans Quack Jailed.—Some time ago a fraud-order was issued against a quack, one Frank Beland of Cairo, Ill. Beland exploited a piece of aphrodisiac quackery under such trade names as "Joy Beans Laboratories" and "Beland Laboratories," selling a preparation that he called "Joy Beans." According to the government report "Joy Beans" were put up by Eli Lilly & Co. After trial, Beland received a jail sentence of ninety days.—(*Jour. A. M. A.*, February 11, 1928, p. 481).

Drugs Applied Through the Skin.—Certain drugs are absorbed by the skin, others not. Nonvolatile substances are not absorbed from aqueous solution. Such substances can be absorbed when applied to the skin in a fatty medium and with considerable friction. Bodies soluble in fat or fat solvents penetrate the skin more readily than water soluble substances. There is not great absorption, however, unless the substance is volatile. Volatile substances are much more readily absorbed through the skin and the degree of their absorbability is

(Continued on adv. page xx)

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TRUTH ABOUT MEDICINES

(Continued from page 184)

probably proportional to their volatility.—(*Jour. A. M. A.*, February 11, 1928, p. 481).

Prevention of Colds qy Ultraviolet Radiation.—In 1926, Barenberg, Friedman and Green found that infants exposed to ultraviolet radiation improved in general health during the first month of treatment but contracted an increased number of colds during the second, third and fourth months. Accordingly, Maughan and Smiley attempted to administer a quantity of ultraviolet radiation equivalent to that to which the ordinary city dweller is exposed during the summer. They conclude that irradiation resulted in a reduction in the frequency of colds. Barenberg and Lewis have completed further experiments in which over-radiation was guarded against. Their results were no better than before. On the one hand are well-controlled experiments with negative results in which the dosage was large. On the other hand are imperfectly controlled experiments and success which the investigators attribute to low dosage. Positive statements, faith and investments may well await further evidence.—(*Jour. A. M. A.*, February 18, 1928, p. 547).

Refractoriness to Insulin.—There is a gradually increasing number of records of diabetic patients who seem to be resistant to the expected remedial action of of insulin. In a recent case, a patient proved relatively refractory to insulin for some months, responded only to enormous doses, and slipped into coma or precoma as soon as these doses were reduced. Tests showed that the refractory condition was not due to an inhibitory substance—an anti-insulin—in the blood. The observers of this case are inclined to believe that the peculiar reactions shown by their patient can best be explained by assuming that the diabetes was not due exclusively to pancreatic insufficiency but to the lack of some substance other than insulin and equally necessary for the metabolism of carbohydrates.—(*Jour. A. M. A.*, February 18, 1928, p. 549).

More Misbranded Nostrums.—The following products have been the subject of prosecution by the Food, Drug and Insecticide Administration of the United States Department of Agriculture which enforces the Federal Food and Drugs Act: Depurativo Cacique (Francisco de Jesus), consisting essentially of mercuric chloride, potassium chloride, sodium sulphate, alcohol and water, with sarsaparilla flavoring. Protecto Spray (Salol Chemical Company), a solution in glycerine of carbolic acid, salicylic acid, boric acid and a trace of volatile oil. Reno's New Health Uterine Tonic (S. B. Leonardi & Company), containing extracts of vegetable material, including berberine, alcohol and water. Kentos (Kentos Laboratories, Inc.), consisting essentially of zinc sulphate, common salt and water, with traces of potassium chlorate and volatile oils. Vernas Lotion (Vernas Chemical Company), consisting essentially of zinc chloride (0.4 percent), cassia oil, glycerine, alcohol and water, colored green. Sanagono (Liaju Company), a solution of alum, zinc sulphate and carbolic acid. White Diarrhea Remedy (Barnes Emulsion Company), a solution of iron (ferrous) sulphate in water. Sannette (Sannette Chemical Company), consisting essentially of boric acid, alum and zinc salts, with a small amount of methyl salicylate, phenol and menthol.—(*Jour. A. M. A.*, February 18, 1928, p. 562).

Joyz Yerba Mate'.—This seems to be a proprietary form of the rather well-known Paraguay tea, which has for its essential ingredients caffeine and tannin. The product is exploited by the International Mate' Co., Inc. In the advertisements it is declared that the preparation has "marvelous medicinal qualities," and that it is of use in rheumatism, kidney troubles and nervous debility. Paraguay tea is a popular drink in South America. The exploiters evidently wish to invest the product with medical qualities of a "patent medicine" type as a means of introducing it into this country.—(*Jour. A. M. A.*, February 25, 1928, p. 637).

DEAR DOCTOR

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THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

ISSUED MONTHLY under Direction of the Council — ALBERT E. BULSON, Jr., B.S., M.D., Editor and Manager

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ORIGINAL ARTICLES

TEN YEARS OF RABIES IN INDIANA*

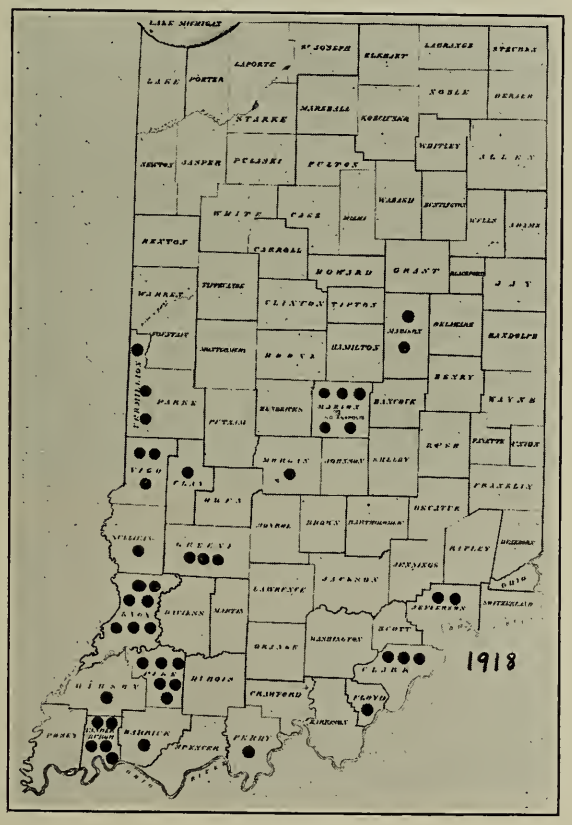
THURMAN B. RICE, M.D.

(Associate Professor Bacteriology and Public Health, Indiana University School of Medicine)

INDIANAPOLIS

Very few diseases are better understood from the standpoint of prevention than rabies. It is true that the germ is not yet certainly known as are the causes of a great many more common infections, but the manner of transmission is perfectly understood, and easily controlled if the people of the state could be made to appreciate the seriousness of the situation. We have efficient means of diagnosis in the microscopic examination of the brain for Negri bodies, or if this is not enough, animal inoculation serves as an extremely accurate check upon the microscopic method. Immunization of man and beast is highly efficient though not absolutely always effective.

In spite of these splendid achievements rabies is on the increase in the United States at the present time, or at least was so until a very short time ago.[1] It is indeed the only disease of an infectious nature that is not showing a satisfactory decline in rate, if one takes into consideration a large area,



1918

Note that there are three primary foci of the disease: 1, extending from Evansville to Terre Haute; 2, about New Albany, 3, about Indianapolis. The disease is practically limited to the southwest quadrant.*



1919

The same three foci are sharply differentiated though the region about Evansville is now free. The Marion County focus has spread and there are a few cases in the northern part of the state.

*Each black dot represents one positively diagnosed animal head.

(1) See "Prevalence of Rabies in United States and the World": Rice; J.A.P.H.A.; April, 1928.

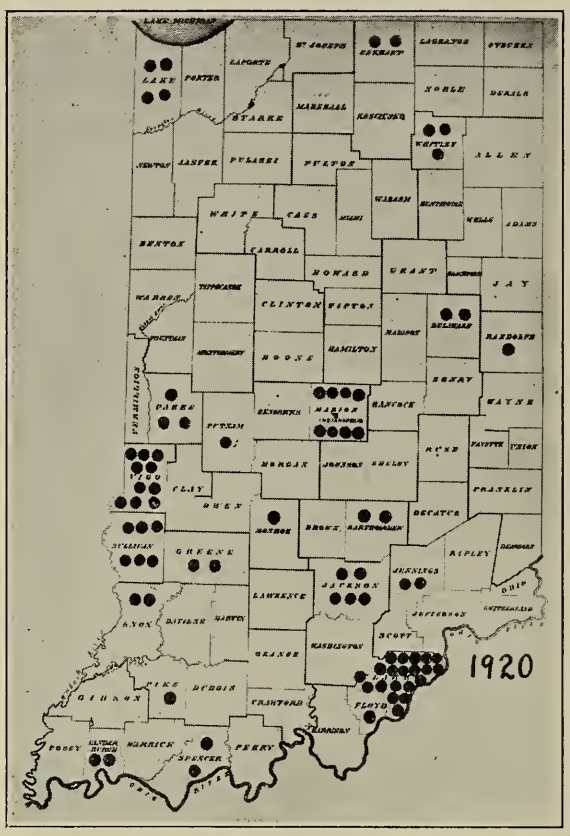
and a considerable period of time. It is probable that the reason for this state of affairs lies in the fact that the great majority of the population is not awake to the magnitude of the rabies problem. A much smaller group have the idea that there is no such disease, but believe that the medical profession is actuated by a desire to persecute the more or less noble companion and pet of the human race—the dog.

The purpose of this paper is to impress the profession first, and the public ultimately, with the seriousness of the situation. The writer, having served as director of the Pasteur Laboratory of the Indiana State Board for the years 1924-26, and having kept in touch with the situation since, has seen the present epidemic develop from a mere speck to a matter of major importance. The following figures representing the past ten years need little elaboration:

Year	Positive brains found Pasteur Laboratory	Patients treated by State B. Health	Expense of maintaining Pasteur Laboratory	Human Deaths
1918	46	69	$ 5,874.27	0
1919	93	33	4,342.00	1
1920	70	46	6,074.54	1
1921	68	37	5,712.55	1
1922	85	49	5,364.12	0
1923	22	24	4,682.56	1
1924	53	42	4,768.87	0
1925	101	92	7,034.82	0
1926	424	364	13,760.60	2
1927	666	1042	18,752.60	2
Total	1630	1798	$76,366.93	8

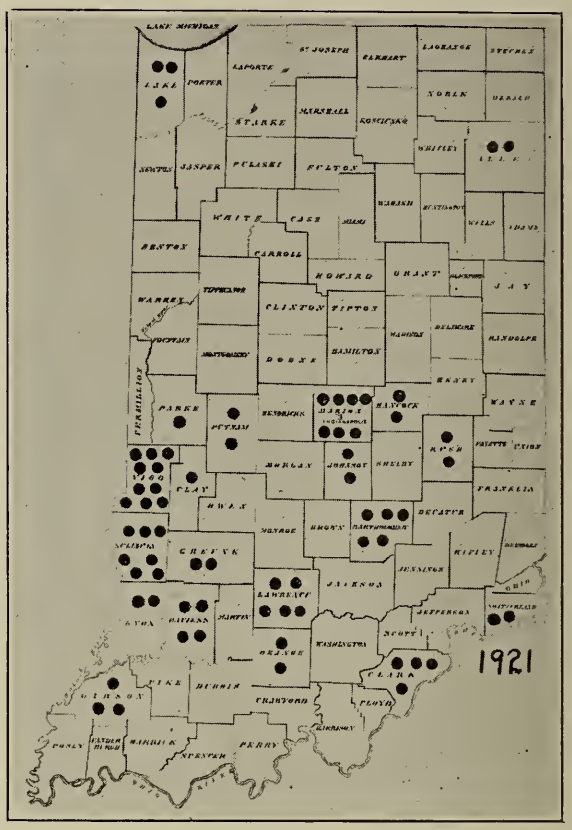
It must not be thought that the above figures represent all of the damage that this disease has done. A great number of animals are not sent in for diagnosis, and there is no way to estimate the number of live stock which have been lost, but their value must run up into very many thousands of dollars. It should be mentioned also that many people who are exposed take treatment of their home physician and so are not included in the above figures. While the number of human deaths is not large, the suffering entailed is not inconsiderable inasmuch as hydrophobia is probably the most dreadful of all deaths. The individual who has seen a human death from this cause will not be disposed to minimize this phase of the matter. If one considers the worry and inconvenience caused by having over a thousand take the treatment in a single year he will be impressed. The author has seen some very terrible wounds inflicted by rabid animals, many of these in small children.

In analyzing the figures representing the expense to the state of making diagnoses and giving treatment it may seem that the expense is disproportionately large during the years when there



1920

The three primary foci are not so clearly shown but are still seen. There are several secondary foci of significance, that in Jackson, Jennings and Bartholomew Counties being most important.

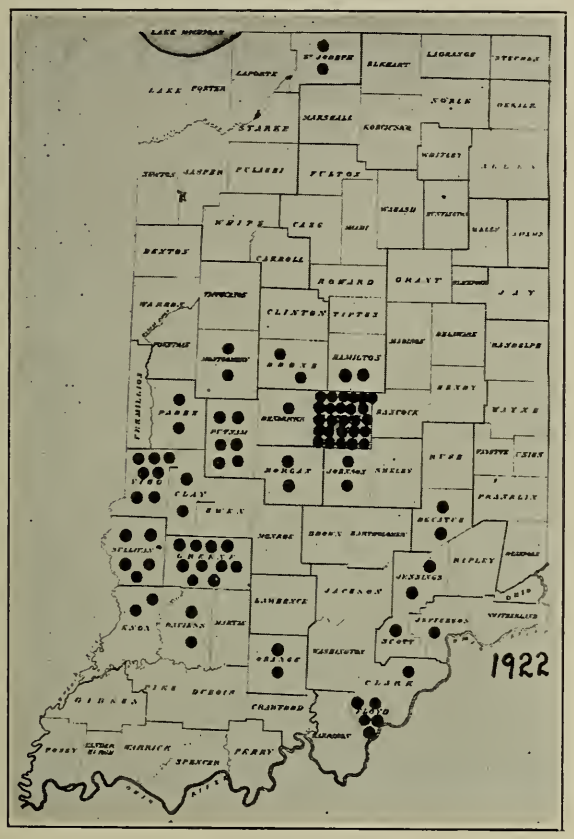


1921

Practically the same distribution of cases is seen for this year as for the previous year.

was comparatively little rabies. This is due to the fact that the overhead expense goes on whether there are many cases or not. The low per capita expense for the year 1927 is largely due to the fact that a majority of the patients treated during that year were from Marion county or close to Indianapolis, and it was not necessary to pay board, lodging, or transportation for such persons taking treatment.

A study of the maps showing the distribution of positively diagnosed cases in animals (positive heads) during the last ten years makes a very



1922

Distribution is much as it has been in recent years but with an increase in all of the primary foci. Disease is dying out in northern and eastern portions.

interesting study in the epidemiology of this disease. Legends accompanying the various maps will point out the more important facts. It might not be amiss to mention, however, the very evident fact that it would have been very easy (comparatively speaking) to stamp out the disease in 1923, but hard indeed four years later, and to call attention to the fact that the focus in Marion county—Indianapolis—has been the center from which the central portion of the state has become contaminated, and that this focus is still increasing.

What is to be done about the matter? Certain facts fundamental to the understanding of the manner and cause of spread of this disease need to be considered in some detail.

A great many animals are subject to rabies, but it is the dog that is responsible for the spread of it almost entirely. Very rarely some other animal may transmit the germ, but without the intermediation of the dog—especially the *stray* dog—the disease would die out in three months. Here then is the point of attack. In spite of the dismal wails of the cranks who put the life of a homeless cur above the public welfare, all ownerless dogs—and *owned* dogs that do not stay at home or with their masters—should be killed as humanely as possible.

The dog is taxable property and this fact should make the owner responsible for any damage done by the same. We dare not allow our cattle, horses or hogs to run loose over the neighbor's property



1923

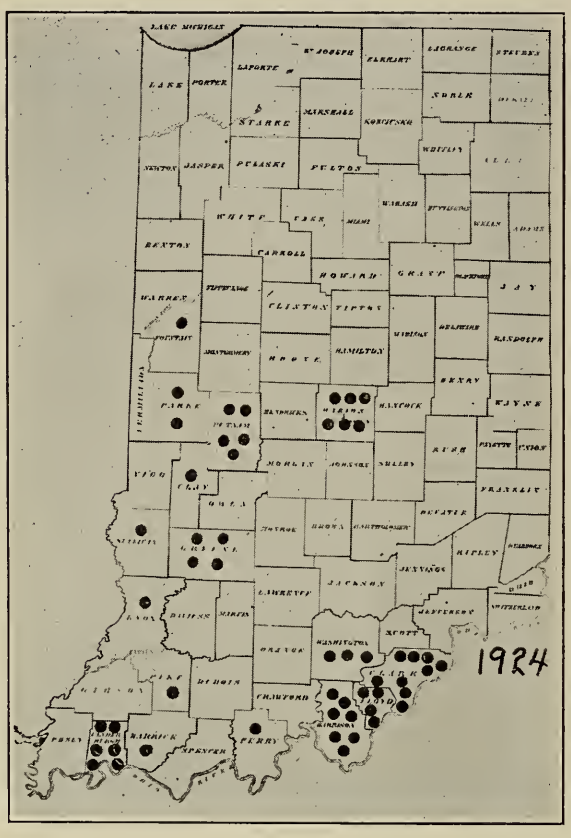
This is the low mark since the Pasteur Laboratory of the Indiana State Board of Health has been organized. Apparently but seven counties are involved though there were most certainly more cases than these in the state. It is interesting to note that the three primary foci are still clearly seen. At this stage a careful control might have practically eliminated the disease.

or on the public highway. Why then should the dog, which is also taxable property?

If the dog has a home and is a treasured pet or watch dog; if he is reasonably well controlled; if he has his taxes and license fee paid, it is quite a different matter. In such case the dog is repaying society for any damage which he may incur. The stray, however, does not pay taxes or fees; he is absolutely worthless; he carries other diseases besides rabies, kills sheep and other stock, and is a menace to the public welfare as a carrier of rabies and a wild animal which may inflict injury to stock and to mankind. The writer has seen so many persons mutilated by such animals that he has lost all sympathy for the silly propaganda of

those who would spare such worthless creatures.

During the present epidemic every dog should be immunized against rabies. This procedure—usually consisting of one injection and costing about one dollar as a rule—is by no means infallible as a means of preventing the disease, as has been observed in Indiana, but for all that is a great help toward preventing the disease. It has been much used in some countries—particularly Japan—and with much success. The immunity produced is by no means absolute and probably does not last longer than a year. For this

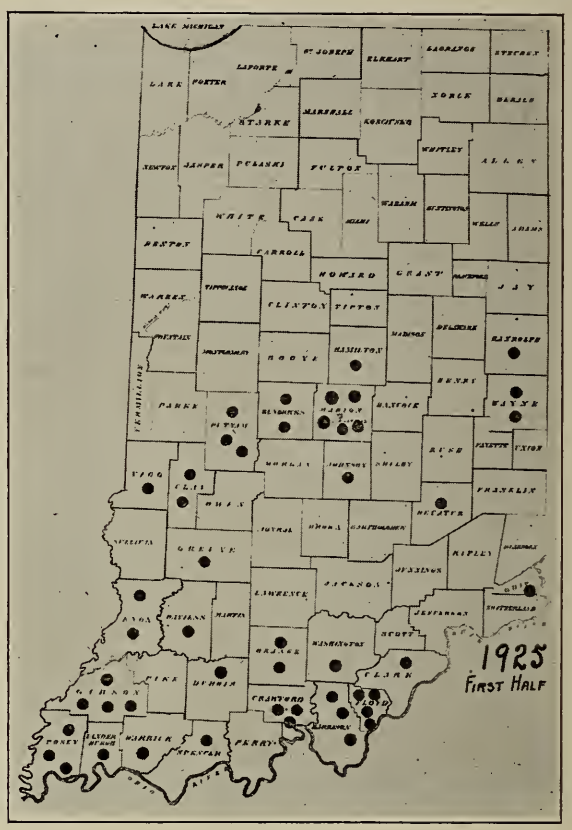


1924
Marked tendency to spread, the three foci still being clearly shown.

reason it is necessary to repeat the process annually.

The muzzling or vaccination of all dogs for a period of a few months would eradicate rabies, but it is impossible to accomplish this much desired end. The order of the State Board of Health to this effect covering the first few months of 1927 was not enforced save in a very few localities and the disease increased rapidly during this period, as can be seen by a glance at the map for that period. If the community will enforce such a rule it is possible to eradicate the disease in a short time. Indeed the entire British Isles have twice been entirely relieved by such measures.

It seems impossible to arouse the entire state to the need of doing something of this sort. It is, therefore, recommended that in case an animal is found rabid in a given community, the sheriff, the health officer, or their deputies, shall be required to seek out all possible contacts and either kill, isolate, immunize or in some adequate way make sure that such an animal may not further jeopardize the community. Inasmuch as the welfare of other communities in the state is at stake the State Board of Health should send representatives with experience in such matters to run down the disease—as indeed they would if it were typhoid or smallpox. The office of the state veterinarian should help in this campaign. Every focus should be religiously traced down instead of being neglected as is usually the case at present except when



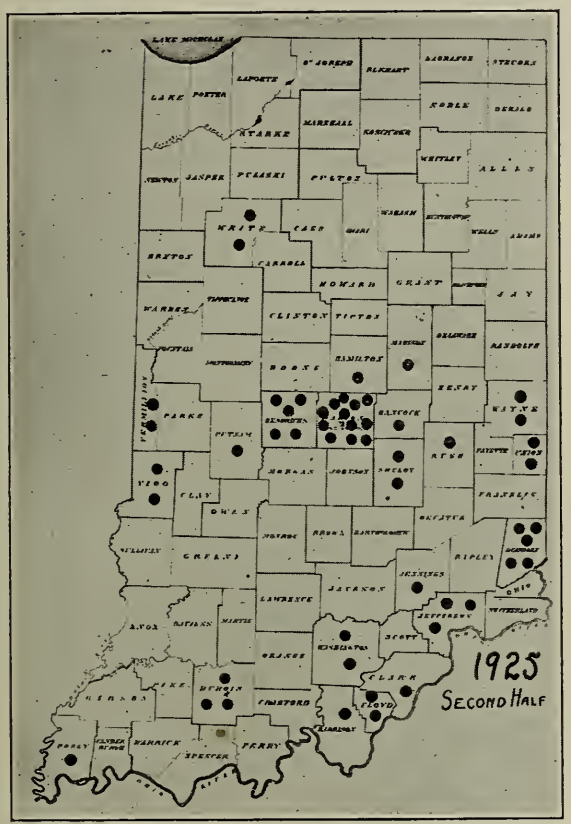
1925—**First Half**
In order to trace the trend of the epidemic the following maps will represent six months of time rather than a whole year as do the preceding ones. There is a distinct tendency for each of the primary foci to spread to adjoining counties. Two new foci are noted on the east, being due to a spread from the State of Ohio, which was at the time suffering from epidemics of the disease in counties adjoining the affected Indiana counties.

some human being is bitten. The present policy of letting the epidemic simply take care of itself cannot be condemned too strongly. It is positively criminal.

All epidemiological experience teaches that an intensive investigation of every case reported, with energetic handling of suspects would very soon produce results. It would be a big task at first, and expensive, but certainly far less expensive than the present epidemic, which is costing great sums in stock lost, in cost of treatment, and in bother and loss of time, not to mention danger, worry, suffering and death.

When persons are bitten by dogs that are possibly rabid, the animals should be shut up for ten

days, if they can be caught without too much risk. If a suspected dog is still well at the end of this time there is no danger to persons bitten before the time of isolation. If the suspected animal has been killed the head should be cut off (never shoot such a dog through the head), put into a tin pail with a tight lid, and then the pail packed in ice in a candy bucket and expressed postpaid to the Pasteur Laboratory at Indianapolis. A negative report is not conclusive evidence of safety and should be disregarded if the clinical symptoms indicate rabies.

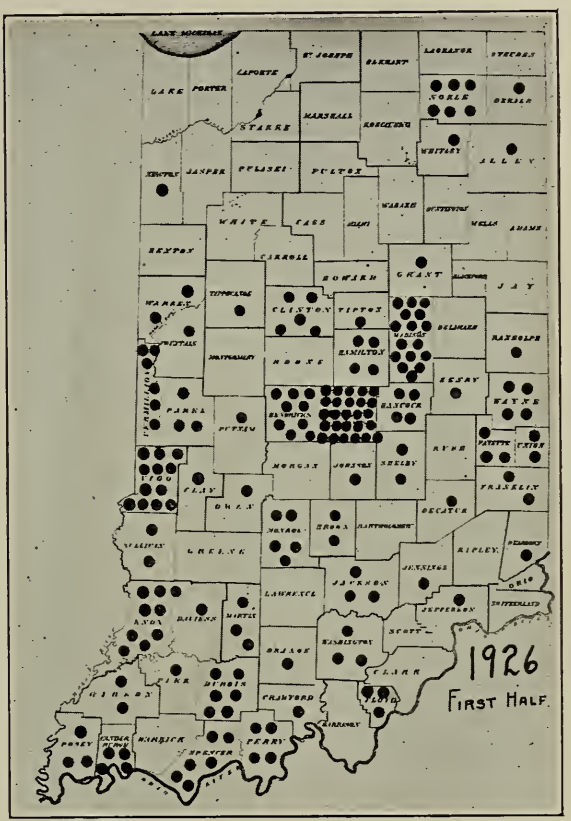


1925—Second Half

We see here the southern and the western foci much decreased but still to be detected. Marion County as usual shows several cases; the two eastern foci have increased considerably. This is the pre-epidemic period as the last half of the year is so liable to be.

In all cases where there is danger of infection to a human being, treatment should be instituted at once either by the family physician if the patient can pay, or by the State Board of Health otherwise. In this connection it is necessary to explain the dilemma in which the Board of Health finds itself in this connection. Very often it has been criticized severely for treating persons who are able to pay. Bear in mind the evident fact that the laboratory has been crushed for the last three years with the task and the expense of treating so many patients and paying their transportation, lodging and board, as many as 104 having taken treatment at a given time. The Board of Health would be overjoyed to have folks take their treatment at home, but there has been no choice in the matter.

The law of the state specifically says that persons presenting certificates signed by the township trustee and the local health officer stating that the patient is without visible means of paying for the treatment *must* be treated free and their expenses paid. This law should be repealed, and another similar to that providing for free antitoxin for indigent persons should be put on the books. This should be brought before the next legislature. It is very true that many people have been treated free when able to pay, but the law was purposely made *liberal* so that *every* person in danger of



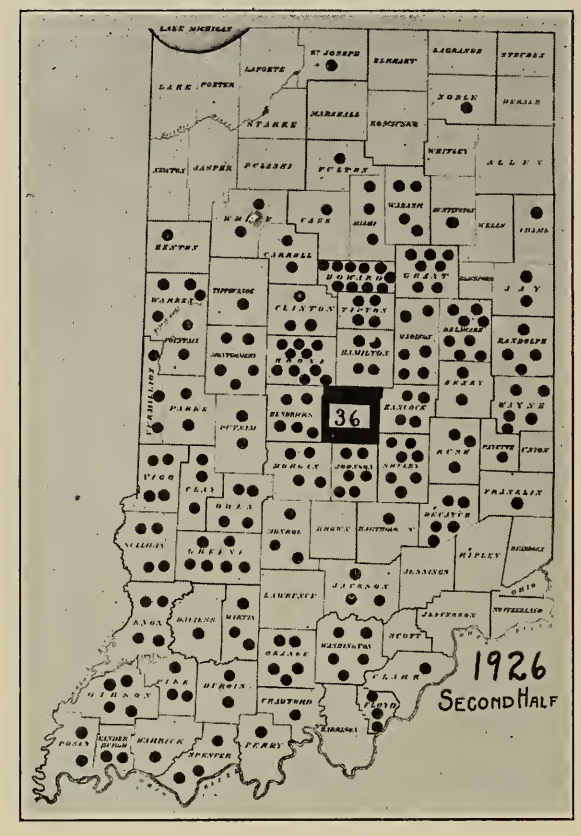
1926—First Half

Here we see the serious effects of neglect. The disease now has spread to a majority of the counties of the state. The three primary foci with the exception of the one about Indianapolis can hardly be made out for the reason that the surrounding regions are as bad as they. Marion County focus is spreading north. The focus about Richmond has become extensive, while the one in the southeastern corner of the state is much improved. A new focus has appeared in the northeast which was thought to have been introduced from Michigan, which had a considerable amount of the disease at this time.

rabies will be sure to get treatment promptly and with the minimum of red tape. In a large percentage of such cases there is no time for delay. A majority of cases where treatment fails to protect were not treated until too much time has passed. The profession should remember, before condemning the State Board of Health, that the certificate entitling a given person to treatment has been signed by the local health officer, who is usually a physician himself. The personnel of the laboratory has no choice in the matter. Besides they have no knowledge of the financial status of the patient and no authority to find out. Recently they have been requiring in addition to the above mentioned

certificates, an affidavit concerning ability to pay, but this affidavit has no legal value, and could not be required if the patient should object. During 1927 at least one person in the state died of rabies who had not been treated until a week had passed. It is not at all impossible that he might have lived if treated sooner. When a patient presents himself with a history of being bitten two or three days before by a dog that has been proved rabid there is no time for quibbling.

As the law is now written the state can treat only those who come to Indianapolis, meaning

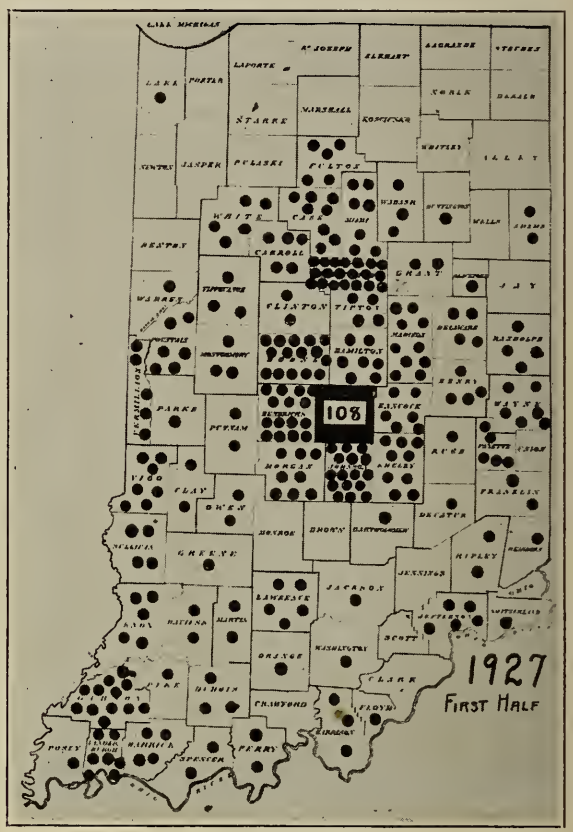


1926—Second Half

This map shows a remarkable uniformity of the disease over the major portion of the state. Marion County leads with thirty-six cases. There is a marked spread to the north. As in the case of other years the disease tends to become diffuse during the latter half of the year. The southeast focus seems to have been wiped out and the Noble County focus is nearly so.

much loss of time to themselves and expense to the state. At the time the law was put on the statutes this provision was necessary because the virus could not be sent out by mail as at the present time. Now, however, the family physician can give it as well as anyone and the law should be changed so that indigent patients might receive treatment in the office of the home physician, the county, township or state paying for the virus. In this connection it should be made clear, however, that a considerable percentage of those who can pay but are receiving free treatment under the present plan are sent by their family physicians for the reason that many physicians feel the lack of experience in handling this condition and are afraid that they might jeopardize the lives of their friends by attempting the immunization. With a spirit of self-sacrifice characteristic of their profession they send their patients to the state laboratory so they may get more experienced treatment. There is no need of this as any physician can give the injections by following the simplest of directions.

It is of interest to know that rabies has in recent years increased greatly in all of the surrounding states for reasons that are unknown. It is strongly suspected, however, that this reason is to be found in the fact that people have in large measure lost



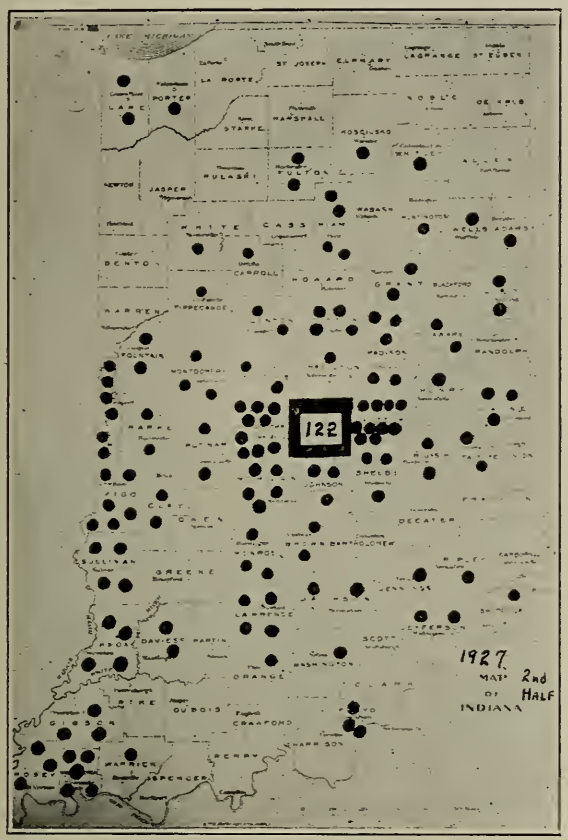
1927—First Half

This is the climax of the result of allowing the Marion County focus to fester. One hundred eight cases in Marion County and a great many in adjoining regions. Howard County was hard hit. Compare this map representing only a half year with earlier maps for whole years. It was during this period that the quarantine and muzzling order of the State Board of Health was issued. This order was not enforced for the reason that people did not appreciate the need of such an order. Officials did nothing and dog owners did nothing. Example of what can be done is seen in Union County. This county had cases in the latter part of 1925 and the earlier part of 1926. It then reformed and took charge of the situation. There have been no cases since, though it has been constantly in the neighboring counties.

their horror of this most terrifying of diseases, believing most probably that it is now rare, and that if bitten they can certainly be saved by taking the Pasteur treatment. Such beliefs are, however, not justified. Both of the cases in human beings during the year 1927 were in persons who had been treated by the full number of injections of as good virus as is on the market. Both were bitten on the lip—very dangerous always; one was treated immediately and died after a very long incubation period; the other began treatment only

after a week had elapsed and became ill the day after the treatment was finished.

As one studies the distribution of rabies over the world it is observed that for the most part it is most prevalent in those parts of the world where enlightenment is at low ebb. If we and the surrounding states wish to escape being so classified ourselves it behooves us to take immediate steps to bring this absolutely preventible disease under control.



1927—Second Half

Marion County continues to increase, 122 cases in six months. Otherwise the state shows the same distribution of a diffuse nature that has been seen in the other maps representing the latter half of the year. There is the same long focus stretching from Evansville to Terre Haute and beyond as has been seen in most of the maps. It is very interesting to speculate how much longer the remainder of the state will tolerate certain portions (particularly Marion County) to serve as a seeding place for this very serious disease. This half year was not so threatening as the corresponding period for 1926, but much worse than that for 1925.

1928—Prediction

There will most certainly be much rabies this year. The first six weeks of the period have shown no great number, but that is hardly to be expected. The spring and late winter months, contrary to popular opinion, are most likely to show a large number of cases. It is not too late at this time (February 15) to do much to control this disease for the coming year. It is probable that the epidemic reached its peak during the first half of 1927, but of this we cannot be sure at the present writing.

BETTER OBSTETRICS*

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NEED FOR BETTER OBSTETRICS

It so happens that in the United States, according to the registration area, which now covers ninety percent of the population, there are dying each year twenty thousand women as a direct result of child-bearing. In addition, there are hundreds of thousands who go on disabled to varying degrees. Indeed, fifty percent of the women who have borne children bear the marks of injury, and sooner or later will suffer from them. The degree of these injuries is vividly manifested by the thousands that flock annually to the hospitals for relief, affording one-third of all surgery performed on women. And all this from a function, generally supposed a normal one, assisted by so-called modern midwifery.

As to the mortality of the infant, astounding, though trustworthy, figures show there are three hundred or more thousand miscarriages occurring each year, general figures giving one to every four pregnancies. Three to five percent, or another one hundred thousand infants, die during delivery. To this is added another one hundred thousand within the first month of life. Indeed, the first day of life bears the highest mortality of the entire human experience, a newly-born babe having a less chance to live one week than an old man of ninety.

During the recent war twenty-eight to thirty-three percent of the young drafted men were found unfit for first class military service because of physical defects, a large percentage of which were traceable to the poor obstetrical care.

These facts readily bespeak discredit to modern obstetrics, and pronouncedly so since there has been no improvement in the last thirty years. That is to say not since we first learned something about anesthesia and asepsis. In contrast, the mortality of general abdominal surgery has been reduced to one or two percent; that of typhoid fever and smallpox almost eliminated; that of diphtheria and scarlet fever to almost nil; that of tuberculosis lessened twenty-five to forty percent (and this in our own state).

As a matter of fact, there is only one disease in the United States that is killing more women of the child-bearing age than child-bearing itself, namely, tuberculosis.

I feel quite sure that a certain significance is being evolved from our modern obstetrical mortality and morbidity. I believe here we have the largest single factor invoking state medicine, and whether we choose state medicine or not, our obstetrical situation is in itself sufficiently influential to bring it about. It is of necessity so, if our nation is to continue to march forward on the feet of little children. As ready evidence in this direction we have our countless municipal dispensary prenatal clinics and maternal welfare organizations, and still more to the point is the application of the Sheppard-Towner bill. This bill never would have been enacted if the doctors had been giving their pregnant women proper care. Surgeons and internists do not have to have federal or state aid to make them perform their work correctly.

*Read before the Marion County Medical Society, Indianapolis, Indiana, Nov. 22, 1927.

THE FEMALE CHILD, A POTENTIAL MOTHER

How valuable the truth included in the saying, "What a race we would be if we might choose our grandparents!" This privilege, of course, is which modern eugenicists are almost willing to concede as practically impossible.

If we cannot begin with our parents we can at least do so with the offspring. In other words, I wish to make the point that one of the most effective factors we may have in bettering obstetrics today is the supervision of the female child. Every female child should be considered a potential mother; and we as physicians should hold that child-bearing is the most important function of the female species.

This supervision should begin during the antenatal time, during which the mother should be given sufficient and proper prenatal care to permit the baby to be born in the most healthful condition and its sustenance at least during its first months of extra uterine life to be maintained by wholesome mothers' milk.

The supervision of the child should then continue, first of all, guarding well its development and nutrition as reflecting upon bony development avoiding pelvic bony deformity in terms of rickets and osteomalacia. Equally important is the guarding of the child against the current diseases of childhood, emphasis being put upon such diseases as diphtheria, which may affect and permanently mar the function of both the heart and kidneys, scarlet fever, striking particularly at the kidney function; mumps, frequently affecting the ovaries to the degree of producing sterility, and no doubt producing a handicapping influence upon normal ovulation and the production of healthy ova. Likewise, focal infections, most frequently found in teeth, tonsils and sinuses, leading so commonly to myocardial, endocardial and nephritic diseases.

The girl should be trained to outdoor athletic life, and when it comes to adolescence, there should be supervision of the menstrual function to the degree at least of assisting the normal. At the time of matrimony, a physical examination should preferably be made beforehand, with the probability of child-bearing considered, or at most after marriage, before that function is undertaken.

'Tis seen in thus outlining the supervision of the young female we are invoking a new obstetrical care not included even in our most up-to-date texts, namely, anteconceptional care. We cannot avoid recognizing the causes that operate to affect the offspring for good or ill prior to the fertilization that leads to the ultimate individual.

Quite contrary to this supervision is the custom of the ordinary community. As a rule, a girl is not supervised after the first few days of life until, perhaps, she reaches the school age of six or seven years hence, except for that relative to current ailments. During school life physical defects are found and attempts are made to correct them, but proper and earlier supervision would have prevented many of these—then, too, parents not infrequently resent the correction. It is interesting to know that in Indianapolis a few years ago when the nutrition and development of the school children was checked up by a careful survey, it was found to the chagrin of many of our "better parents," that the poorly developed children were found on the north side in the best residential section, while the better developed children were found in the southwestern section among the colored and "wop" element.

The athletic life of the average girl today is very much limited. Instead all effort is spent toward the development of her central nervous system in terms of educatioin. The high school girl not infrequently dislikes gymnasium work, as shown by the fact that a fair percentage go before their family physician endeavoring to be excused from that work, not seldomly on unwarranted claims. The average girl in the general civilized community has no manual experience whatever. She continues through high school, enters college, and there a little more athletics may be taken on as required for credits, but too late and insufficient to do ample good.

Before graduation, or shortly after, marriage frequently occurs and soon after motherhood begins, or as often happens, matrimony is postponed until the late twenties when it will be possible for the eager and willing though perhaps incapable husband to furnish a retiring livelihood. As a result at least among our better classes, which also represent our better stock, we find an increasing number of primiparous patients nearer thirty than twenty years of age. This results in an equal hardship upon both the mother and the child, in that a girl of sixteen can deliver a baby with more ease and less injury to herself and baby than a woman of thirty. Thus as custom has it, we have the female of the species going through her early years of life, approaching the most important biological function she possesses in a physical state that does not by any means equip her for it. The same college girl who suddenly has labor thrown upon her has to go through more strenuous physical exertion than her brother on the football field who has had months and seasons of training. And thus an important reason why more labors are pathological than physiological—not necessarily pathological because of gross lacerations and other trauma, but from the shock to the overly civilized being.

PRENATAL CARE

After impregnation, or even upon the suspicion of pregnancy, the patient should be instructed to call upon her physician for a so-called prenatal examination and the introduction of prenatal care.

First of all, a rather complete history should be taken, covering particularly those parental diseases that might be transmissible or at least the predisposition to them, *i. e.*, diabetes, hemaphelia, tuberculosis, rheumatism, Bright's disease and mental and nervous diseases. Then such illnesses of her personal experience as the following should be noted: diphtheria, scarlet fever, tonsillitis, kid-

ney, pulmonary and cardiac and venereal disease. If she is a multiparous patient, inquiry should be made relative to her past child-bearing, the nature of the labors, size of the babies, the complications, and the present health of the children.

It is also important to learn the history regarding miscarriages, being ever alert for lues. Then inquiry should be made of her symptoms since the beginning of pregnancy, particularly going over the prodromals of eclampsia and placenta previa. *Laying stress upon these two complications alone more than justifies prenatal care, and no prenatal visit is half performed if the physician does not inquire specifically if the patient has not been bothered since the last visit with nausea, headache (especially vertex), ocular disturbances, epigastric pain, edema, and bloody vaginal discharge of any amount, and this inquiry made despite the patient may have reported that she has had no complaint to offer.* This emphasis is urged because 'tis these two complications of the ante-natal period especially during the latter half of gestation that hold a most significant mortality either prior to or at delivery that is impossible to avert by most skilled attention at birth alone, and is reached only by strictest prenatal supervision.

A physical examination should be complete, and not limited merely to the abdomen containing the pyriform tumor mass, which will in all probability disappear during the conventional hour of 2 a. m. at some indefinite future date. What the patient will do with that given tumor mass at labor will depend on her physical condition. Therefore, it is important to look for sources of focal infection that usually lurk in the teeth, tonsils, sinuses, gall-bladder and appendix. The thyroid should be noticed and a careful examination of the heart and lungs, kidneys, lower extremities and reflexes.

It is well to take a blood Wassermann on each case in that it is definitely known that syphilis is responsible for twenty-six percent of all miscarriages; that seven to eight percent of all pregnant women give a positive Wassermann, and only one in four will give positive evidence in the way of history or examination. It is important to learn of the lues early in pregnancy, that treatment may be instituted promptly, and incidentally, in giving the treatment, the pregnancy is disregarded. One big advantage in giving treatment during pregnancy is that two patients are treated instead of one. By the ante-natal leutic care miscarriages and premature births may be avoided, and babies born alive, not infrequently Wassermann free.

The urine should always be examined for sugar and albumen. If sugar is found the mistake must not be made of immediately calling the case one of diabetes, in that a large proportion of pregnant women at some time during pregnancy bear lactose in the urine, which is physiological and is to be differentiated from glucose of true diabetes complicated by pregnancy, or vice versa. Pregnancy complicated by diabetes holds a much more favorable prognosis than formerly, and through intelligent diabetic care assisted with the use of insulin it is very rarely necessary to empty the uterus.

As to albumen, the nitric acid, or Heller's ring test, is most practical, in that it demonstrates only pathological albumen. A specimen of urine should not be reported positive for albumen unless it is a catheterized specimen, because of possible contamination by vaginal secretions.

The most important test that is made in the care of the prenatal case is the blood pressure. Of all the agencies and appliances we have for examining pregnant women, the blood pressure apparatus comes first, and if all but one were to be discarded, it is the one I should retain.

Just a word about blood pressure. Its increase is important in that it will indicate a developing pre-eclampsia, and in practically all instances before indicated by the urine. For instance, with a patient showing a systolic of 120, this will gradually be raised to 130, thence to 140 or 150 before there is a trace of albumen. If the blood pressure reaches 150, the patient is toxic, and should be put to bed and treatment instituted. If the pressure continues to rise, say to 170, 180 or 200, despite seven to ten days' treatment, and with or without other symptoms, do not wait for something to pop, *i. e.*, convulsions—empty the uterus, ever keeping in mind the possibility of a single or double fatality, or at least the danger of permanent injury to the maternal kidneys and retinæ.

A second point about blood-pressure: In most of our teaching and discussion of blood pressure relative to obstetrics the sole attention is directed toward the high blood pressure. It has been my personal experience to a degree that I feel certain in stating that there is just as much, if not more, practical obstetrics connected with a low blood pressure as with a high. If we have a systolic blood pressure of 100 which slowly descends to 90 or 80, or still more significant, a systolic of 110 and a diastolic of 60, with the diastolic dropping as observation continues during gestation, that is a pathological circulatory condition and that patient should be carefully observed during the prenatal period and assisted at the time of delivery at least as soon as the cervix is fully dilated.

Another important part of the prenatal examination is pelvimetry. Here again our academic teaching emphasizes only the pelvimetry of the inlet. It is fair to infer that this emphasis has come about largely through the development and popularity of the Cæsarean section. Pelvimetry of the inlet has no practical value except the classification of the type of the pelvis, such as flat, justo major, justo minor, obliquely contracted, and so on. *There is only one true pelvimeter of the inlet, and that is the baby's head.* We don't mind what the measurements of the inlet are so long as the baby's head may be made to pass the superior strait.

A practical point hereto related is that in case

of a primiparous patient where lightening has not occurred within seven or ten days of the carefully calculated date of delivery, it is good obstetrics to endeavor to engage the head with manual pressure from above, even though it is necessary to administer some light form of anesthetic, nitrous oxide being very desirable. If the head cannot be engaged at this time it is well to anticipate difficulties and be prepared to meet them as the case warrants.

Pelvimetry of the outlet is more important than pelvimetry of the inlet, because the inlet can be measured directly with the baby's head before or at the beginning of labor, while it cannot be applied to the outlet until late in labor, and then often too late. It so happens that forty-four percent of all pelvic deformities of the American white women is that of the funnel type, *i. e.*, the pelvis with a contracted outlet. Unless we measure the outlet we have no way of surmising this contracture. At least nine-tenths of obstetric difficulties are met at the outlet, and not at the inlet. Nine times as much morbidity and mortality occurs at the outlet as compared with that of the inlet. By far most obstetrical assistance is necessitated at the outlet—at least seventy-five percent of all forceps work is incurred because of this deformity.

A contracted outlet leads to difficulties in performing a version and usually leads to gross traumatism and not infrequently the loss of the baby. The same is true in breech extraction in the hold-up of the after-coming head. The narrowed outlet leads to laceration of the perineum, usually of the second and third degree, or the performing of the episotomy.

The transverse of the outlet normally is eleven cm. It is difficult to deliver a seven-pound baby with a transverse less than eight cm. The simplest way to measure the transverse of the outlet is by placing the closed fist transversely between the ischial tuberosities. The average fist is eight cm. wide, and if it passes comfortably, it means a seven-pound baby should be delivered without special difficulty. If the diameter is less than eight cm., then it behooves the man in charge to ascertain, with assistance if necessary, the extent of the so-called posterior sagittal, the diameter reaching posteriorily from the middle of the transverse to the tip of the sacrum, normally ten cm. If this diameter, plus the transverse diameter, is less than fifteen cm., it is fair to assume you are dealing with an obstructive outlet, and a Cæsarean is indicated if the baby is at least seven pounds in size. In other words, there are indications for Cæsarean at the outlet, the same as at the inlet, and my experience has been they are equally frequent. It would seem then that the eight cm. transverse diameter is to the outlet as the eight cm. conjugate vera is to the inlet.

It is also important to know if the transverse diameter is short in governing the type of episiotomy to be employed. If a definite contraction exists the median episiotomy is contra-indicated in that it would lead to laceration through the sphincter and rectum. One of the desires of better obstetrics is leaving the sphincter intact, and, therefore, in such a case the medio-lateral episiotomy is of the first choice.

Palpation of the baby is another very important part of prenatal examination and care. Mal-presentations should be corrected, and especially that of the breech by external version in that the mortality of the breech is five times that of the cephalic presentation. One should become so proficient in palpation combined with auscultation and rectal examination that the vaginal examination at delivery may be eliminated.

As routine, a prenatal patient should be seen every month up to the sixth month, every two weeks during the seventh and eighth months, and every week the last month.

Most obstetric mortality comes from four sources, hemorrhage, eclampsia, disproportion, and sepsis. Proper prenatal care eliminates eighty percent of the mortality from eclampsia, fifty percent from placenta previa, more than fifty percent in disproportion cases, and a marked reduction from that of sepsis. Here, then, we have within our control a prevention of a big part of obstetric mortality, and I am of the conviction that in the general run of obstetrics, efficient prenatal care is more important than adequate care at the time of delivery, in that it bespeaks greater reduction in mortality and morbidity. More than that, the mortality of the first few days of life can be reached only through prenatal care. In the United States fifty thousand babies could be saved annually if all women were supervised prenatally. *Today prenatal care is the largest and most productive field in the entire scope of preventive medicine.*

PARTUM AND PUERPERAL CARE

At delivery let us emphasize the "dry" preparation, *i. e.*, the application of fifty percent tincture of iodine, or five percent mercurochrome, following a careful shave of the pubis and vulva, into the entroitus, and over the perineal and anal area, after the wide painting of the anterior and inner surfaces of the thighs and lower abdomen. This dry preparation is especially enhanced if the parts are first thoroughly swabbed with ether or benzine, and offers the great advantage over the so-called "wet" or scrubbing preparation in that it does not afford the washing of contamination into the vagina. Thus the skin and mucous membranes are as adequately prepared as for a major vaginal operation.

During the conduct of the labor let us lay stress upon the rectal examination. External palpation combined with rectal examination gives one all the needed information in ninety-five percent of the cases. The rectal examination is quickly performed, requires no preparation of the patient, and is much less contaminating than the vaginal. In way of a little humorous though practical advice, it is always well upon doing the first rectal upon a patient to inform her you are going to

examine her *per rectum,* or she may erroneously think the doctor does not know by which route the baby is to be born. How sad to relate, poor obstetrics too frequently admits of the rectal route.

The accoucher must ever keep in mind that he is dealing with two lives, and a check on both individuals must be maintained throughout labor. He accordingly observes the fetal heart rate at least every half-hour, and interprets a rise in rate to 160 or a fall below 100 as signaling fetal distress, and, conditions permitting, proceeds to expedite the labor. During the second stage a rise in maternal pulse to 100, signs of fetal distress, and an hour and one-half or two hours arrest in the advance of the presenting part, call for manual interference.

Better obstetrics admits of no use of pituitrin during the first and second stages of labor, but on the contrary solicits its aid at the immediate beginning of the third stage, *i. e.,* before the birth of the placenta. It is administered hypodermatically in one-half to one cc. amounts, and preferably in the gluteal region. After the third stage the action of the pituitrin is supplanted by the intramuscular injection (also into the gluteal region) of aseptic ergot, or better still, gynergen.

Better obstetrics demands special care in conduct of the third stage, in that it bears more maternal mortality than the first and second stages combined. Manual expression of the placenta is not attempted under fifteen to thirty minutes. Above all, traction on the cord is never permitted, retained membranes are disregarded, and retained placental tissue is manually removed. Better obstetrics further demands that a fourth stage be added to the classic three, namely, an hour's period of observation following the completion of the third stage, alert for post-partum hemorrhage, either external or concealed in a ballooning uterus, and post-delivery shock, and a survey of the child's condition. Of course, it is during this hour that needed repair is performed, always under most rigid asepsis. Secondary repair is no longer advocated.

The patient, following delivery, should be kept in bed, ordinarily twelve to fourteen days, and should be instructed to lie about for another week. During this time she is given proper exercises, beginning the third or fourth day, lying on the face one-half to one hour three times daily. This permits the uterus to fall forward in normal position over the bladder, facilitates drainage, and thereby expedites involution. On the fifth or sixth day, elevating the extended lower limbs toward the ceiling eight to ten times twice daily. After the eighth day, raise the head and trunk to an upright position eight to ten times, with the arms folded across the chest. These exercises greatly increase the patient's circulatory and muscle tone, as well as afford her entertainment.

The patient is advised to be in bed two to three weeks during the post-partum convalescence not because she is ill, but to assist the pelvic organs to attain their original relation and position. I frequently reconcile the patient by explaining that the womb after delivery weighs two pounds, while the non-impregnated uterus weighs but two ounces, and that it requires two months to retrogress to the two-ounce size; that the ligaments holding the uterus are three to four times their normal length, and that the vagina has been dilated five to six times its normal diameter. A patient getting up prematurely is apt to have pelvic disorders because of retroversion or dropping of the enlarged unsupported uterus, down through the relaxed vagina, and as a result she represents a larger group of the number who report back in a few months to the gynecologist, complaining of dragging, backache and so-called female disease.

I further encourage by saying that with two to three weeks' rest following delivery, assisted by properly instituted exercises, she should in three months' time not be physically conscious of having borne a child. This with the delivery of a healthy baby, which she is able to nurse, is the goal of modern obstetrics.

The clotting and bleeding time should be taken on the baby forty-eight hours after birth, and if questionable again on the tenth day. Boy babies, nothing contra-indicating, should be circumcised, preferably about the eighth or tenth day, that is about the time the birth weight has been regained. This usually allows time for the circumcision to be healed before the baby leaves the hospital.

ANESTHESIA

In considering anesthesia in obstetrics, I am sure that some time in the future boards of health will require that all women in labor be given anesthesia. There is a discrepancy in human nature that creates no casual interest. Permit a woman to be injured or insulted on a public street corner, and a dozen men. even the street laborer, will jump forward to assist or defend her. Yet in our modern hospitals women in labor can frequently be heard suffering most excruciating pain, making sufficient noise to arouse the whole wing of the building, while hyper-trained physicians pass calmly by, or perhaps enjoy sleep in an adjoining room, or still more to their comfort, engage in slumber in their home bed, waiting till notified that the head is on the perineum. The drama is intensified when you visualize the lot of most women who are left to combat single-handed the situation in their homes. It is true that the physician may be exhausted and in dire need of rest; however, our topic is "better obstetrics." There is nothing more brutal or primitive in the whole field of medicine than a woman unassisted with anesthesia during this period of travail. What is wrong with men's natures when they permit women at the most crucial period of their lives to suffer indescribable physical and mental pain and duress just because they possess the fortitude of a martyr!

If anesthesia is practical and should apply to our surgical cases, it certainly should apply to our

obstetrical cases. At this particular time it is quite easy to recommend and insist upon anesthesia, in that within the last decade there has been developed the so-called rectal analgesia or anesthesia. This is the largest benefaction that has come to the obstetric field, relative to anesthesia, largely so because it is so generally applicable. It can be given by anyone, anywhere, even in a barn, if necessary. It can be given any time in labor, if well started and is met with only one contra-indication, namely colitis. We here then have a fool-proof form of anesthesia to which every woman in labor is entitled.

Personally, I prefer to start with rectal anesthesia preceded by hypodermic morphine, and followed by nitrous oxide, and during the perineal stage the switching on of surgical ether or chloroform. (Of late ethylene gas alone following the morphine throughout the first, second and third stages is rapidly winning my favor). Thus the patient is already under anesthesia for the usual repair work.

HOSPITALIZATION

Let us give, or strive to give, all our patients hospital deliveries. A primiparous patient has four times the chance, and a multiparous patient twice the chance. in a hospital that she has in the home. The baby's chances are proportionately increased. The obstetrical millennium will be at hand when all women are confined in hospitals.

At this point a word of special credit is due the local profession, the Board of Health, and the various other interested agencies, in that in Indianapolis this millennium is being rapidly reached. In 1916 one woman in ten received hospital delivery, in 1921 one in five, and in 1926 one in three. In other words, within a decade the number has been trebled. I am sure this is a record and I wonder if many general communities have equaled it.

If it is to the patient's advantage to bring our appendix, hernia and tonsil cases to the hospital it is certainly more than doubly important that we give our obstetric cases hospital care. In dealing with an obstetric case we are handling two lives, one having a guiding and protective influence over the other, and as a rule others besides, the other representing a potential citizen, whose value to the state increases as he grows older. Thus, obstetric work is decidedly constructive, and progressive life of the community is basically dependent upon it.

The obstetric case presents three surgical wounds and not one, namely, the mother's nipples, her traumatized genital tract, and the baby's umbilical wound. The average complications are five times that of the appendectomy. When physicians once place the same surgical value upon obstetric patients as a surgeon does upon appendix cases, we will no longer have trouble in getting physicians to send their patients to the hospital. A strong ray of promising light is already brilliantly cast across the horizon in that today practically all physicians and medical students have their own wives delivered in hospitals.

However, good obstetrics may call for hospitalization of the patients, better obstetrics demands special built, better equipped, and better organized maternity hospitals. We can no longer continue solicitation for hospitalization and at the same time maintain a mortality from infection within our hospitals that exceeds that of home deliveries. First of all, the maternity service in the general hospital is to be condemned and dispensed with if we ever are to combat this situation. As it is often women's lives are saved by excellent prenatal care, and then die of puerperal infection. As a rule, the maternity is the neglected portion of the hospital—usually occupies the least desirable space in the building and is equipped with discarded paraphernalia of the other departments. Anything seems to be good enough for the obstetrician in most hospitals. Rarely is a resident in charge, and the internes have a rotating service, allowing a very limited period of their time to the service. Nursing supervisors not seldomly are found inadequately trained. Not one hospital in ten furnishes enough capable anesthetists to the obstetric department. The surgical department by one method or another dictates who may or may not perform in that department, but in the delivery room it is every man's game, even though he be only the very occasional accoucheur who still practices as they were taught twenty-five or thirty years ago, not seldomly depending on the ever-willing though sometimes incapable interne. The aseptic technique of the department is often slack, visitors enter delivery room without gown, the attendant often goes without mask, the supervisor sometimes has other general hospital duties, and most of all to this point is the Schnitzen-fest parading up and down the corridors. Another most important source of infective influence is that arising from the medical, surgical, gynecological and pediatric wards, the laboratory and autopsy room, via the hospital servants, the internes and nurses.

The solution: First of all, let the full surgical dignity of the obstetric case be recognized and properly evaluated. Then the confinement room will be as well built and as properly adapted to the work as are the operating rooms. The equipment will be of like quality and completeness. The staff will be equivalent in number, the internes and nurses, and supervisors will be equal to those in surgery. The aseptic technique should even surpass in thoroughness that of the surgery. No detail considered necessary in the operating room may be omitted from the delivery room.

No better illustration of these requirements is to be found in the United States than in that of the William H. Coleman Maternity, which in its thoroughness of modern conception and equipment bespeaks but too well the lofty obstetrical ideal of that recently deceased member[1] of our society to whose sole efforts the community and state are

more indebted for its materialization than any other individual. His personality permeates throughout the building, and we accept it as a most fitting memorial.

Ideally, the maternity should be a separate, detached building with its own laundry, kitchen, and quarters for help. It should have a special isolation department for both suspected and infected mothers and infants, and, not least, an ample solarium.

In that 7,000 mothers are being confined annually in Indianapolis, and that the present hospital capacity is adequate only for less than forty percent of that number, and in that less than half that accommodation meets the requirements above stated, it would seem that Indianapolis is in immediate need of another first-class maternity hospital of not less than one hundred bed capacity.

FOLLOW-UP CARE

Another very valuable care, though not stressed in modern texts, that is included in better obstetrics, is the follow-up care after the puerperium. It is quite imperative that the mother and baby be examined six weeks after delivery, the baby relative to umbilicus and circumcision wound, if that operation has been performed, the mother for blood-pressure, albuminuria and thorough pelvic examination, especially on the lookout for misplacement and early endocervicitis. The mother should again be examined at three months, six months and a year after delivery. If at these visits conditions are found warranting correction, such care is given over a time required for it.

By such supervision sixty percent of retroversions are cured without surgery by replacement of the uterus, usually supplemented by the pessary. The most common post-partum sequela, leucorrhœa, is now cured in one hundred percent of cases by the use of the electric cautery, as applied in the office. By getting rid of the endocervicitis you are not only sparing the patient of a very annoying discomfort, but removing a very common source of focal infection. In the last year I have had three or four cases of albuminuria promptly clear up after eradication of the endocervicitis in one and not more than two treatments.

This postpartum care in most cases is prenatal care for the pregnancy that usually follows in the next year or two.

As to the baby, the ideal would be turning it over to a pediatrician's care as soon as the cord is cut. I'm sure this would meet the most happy approval of any practitioner or obstetrician. Although that goal lies in the far distance, its reality is becoming more evident in every modern community of appreciable size. Until then, since the first year of a baby's life is the most important as relates its future health, someone with medical ability should supervise it during that time. The conscientious family physician avails himself of a great service here, and if, as sometimes occurs of necessity, the less desirable, the accoucher, should give this service. This is not especially difficult if he does so in conjunction with the year's postpartum care. Personally I extend this care only to the normal healthy baby as pertains to food, weaning, clothing and so on, having the parents maintain an accurate weight chart throughout the year. As soon as the infant presents a disease or illness, or becomes a "feeding" case, the parents are asked to take it to the family physician or a pediatrician, which they usually gladly do. In addition in printed instructions I advise them to take the infant, though normal, to a pediatrician every three to six months for a general examination. I admit that although this care bridges an important gap otherwise left open, it is a make-shift of the first order and I shall readily endorse an early solution.

BETTER OBSTETRICAL TRAINING

Back of all the above recommendations named for the betterment of obstetrics comes most fundamentally better obstetrical training of the profession.

First of all, the midwife must be eradicated. Better obstetrics cannot accept the dual standard of the midwife attending the poor and uncomplicated cases, and the doctor the rich and complicated. The problem of her eradication is no small one in that she has a more favorable mortality than the regular physician. But at that, her mortality is too high. The problem is no less perplexing when we learn she delivers forty percent of all American babies and that in certain cities her training is supported, and her profession endorsed, by some of the leading obstetricians in the country, the plea being that it is impossible to have obstetrics sufficiently taken care of by men of medicine. In the same cities, however, diseased tonsils and appendices do not go begging for care.

In other words, surgery is well covered, obstetrics neglected. This in large part comes about by the small fee usually associated with an obstetric case. If we give people service, they gladly pay for it. If you give them "Ford" service, you do and should receive a "Ford" fee. If you give a "Packard" service, they willingly pay a "Packard" fee.

Secondly, *I for one am opposed to the teaching of obstetrics in the home.* So long as we teach obstetrics in the home, just so long will our graduates go out into the various communities and continue to practice obstetrics in the home. As above stated, if we ever get obstetrics on the plane it should be, it is a hospital proposition. Then, too, as a colleague[2] expressed himself in a paper five years ago, "Outdoor obstetrics is, at its best, of little real value to the student. The real foundation of obstetrical care and treatment is proper diagnosis—that a large and well-equipped maternity is the best place to teach and practice obstetrics." We may congratulate that gentleman in that he now has the happy opportunity and unlimited power to put into effect the application of that statement.[3]

I take issue with several of the better minds,

including the oft-quoted DeLee, "that since most babies are born in the home we must train the doctors how to take care of births in these unfavorable surroundings," in that I am free to wager that an interne having had but a four months' hospital obstetrical training will stage a better home delivery than the non-hospital trained physician who has delivered babies in the "sticks" for twenty years.

Thirdly, obstetrics is surgery, and an obstetrical training precludes a surgical training. The best obstetricians are men who do their own surgical gynecology. Their judgment in interfering early is more alert, and frequently Cæsareans are not postponed till too late. They are more dextrous with their instruments, do better repair work, and are much more competent in handling labor catastrophes.

Fourthly, there should be more allowance for obstetrical teaching in the school curriculum. A recent close survey shows that the general practitioner devotes fifty percent of his practice to medicine, thirty-five percent to obstetrics, and fifteen percent to minor surgery, and life insurance examinations. Despite this actual rating, the curriculum in our A schools allows but four to six percent of the hours while surgery is given twenty to thirty percent of the teaching hours. Rightfully obstetrics should have at least fifteen to twenty percent of the total hours.

Fifthly, in teaching our students it is not necessary that we make graduate obstetricians out of them unless they elect—a much simpler achievement will suffice, merely that they are sufficiently taught to recognize the abnormal, and then realize and admit their own limitations. Let it be instilled into them that many obstetric cases are a two-man job. And that the second man is not necessarily a general surgeon, nine-tenths of whose obstetric judgment and skill is so frequently expressed only by Cæsarean.

Primarily lead them to cultivate an obstetrical conscience—that an obstetrical case means two lives and not one—thus distinguishing from the usual pneumonia or gall-bladder case. That labor is no longer considered a normal process. Nature had intended it be without danger or damage to mother or child, but at present it is always attended by both. That good prenatal care is perhaps the most valuable part of obstetrical care. That proper hospitalization is a very important factor in reducing obstetrical mortality and morbidity. That anesthesia is an imperative adjunct to better obstetrics. That an obstetrical case should not be discharged until her physical condition has been restored at least equal to that prior to conception. This may necessitate several months' post-partum care. That an average obstetrical case may rightfully expect as much as twenty months' supervision.

More specifically speaking, let us assist him to develop a strong aseptic conscience—so strong that abdominal surgeons in choosing their internes will require that they first complete an obstetrical interneship; so strong that they would rather curette an acute diphtheritic throat than a septic uterus. That they have less aseptic fear in performing an internal podalic version than in the manual extraction of a placenta. That they consider all bleeding during gestation, especially during the latter half, that of placenta previa, till ruled out by accurate diagnosis. That they consider a forceps delivery a major operation. That Cæsarean in the treatment of acute eclampsia is the last form of treatment to be considered. That the obstetric use of pituitrin, though very valuable if used within certain narrow limitations, it is a most treacherous drug if improperly employed.

Lastly, let us inculcate within them such an inspiration and esteem for obstetrics that they will insist upon a first-class obstetrical service during, or following, their general interneship; that they will, after entering practice, take advantage of post-graduate clinical courses every three to five years; that they further keep abreast by subscribing freely to obstetrical journals. And that, finally, each man become a live, enthusiastic, obstetric power within his community, ever lending influence to the betterment of obstetrics.

In conclusion, the general obstetrical mortality and morbidity have been so long stationary as to become a permanent reproach upon the profession of this country. There is an immediate, if not imperative, demand for better obstetrics, and the best minds of the profession should be concerned.

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RUPTURE OF THE INTESTINE WITHOUT EXTERNAL WOUND*

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Cause: Usually a rupture of the bowel without external wound takes place as a result of direct violence. In the two cases herein reported, the patients were struck by automobiles; the abdomen was directly injured in one and indirectly by the fall in the other. Eckles reports a boy who bumped into another boy sustaining a ruptured intestine. Kicks by horses and mules are frequently reported as examples of direct violence.

A few cases have been reported where indirect violence was the cause. A severe fall, landing on the feet or buttocks, may cause a rupture of the intestine. Also a severe blow on the back or loin may produce this calamity.

The exact mechanics of the rupture probably varies in different cases. In most cases it is due to (1) oscillation or (2) compression. Usually the gut is compressed against the vertebral column or pelvis. E. W. Andrews published five cases in which he believed the bowel was cut by the prom-

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ontory of the sacrum. If the intestine contains fluid it may rupture as a result of violent shaking or oscillation. W. W. Keen states that experiments on cadavers show that the ileocœcal valve opens under one and one-half pounds pressure and that it takes ten pounds of pressure to rupture a gut by air. If the intestine is filled with fluid, however, only about four pounds pressure is required. The gut is probably "caught" in a certain way when oscillation is the cause. The rent is on the side farthest from the mesentery. When compression is at fault the rupture is more extensive and usually involves the whole circumference of the bowel, or portions of it in one or more places.

Predisposing causes may be briefly classified as: (1) conditions in the abdominal wall, (2) the bowel itself, and (3) factors rendering the intestines less mobile or immobile. Obviously a relaxed belly is more liable to injury than a rigid or well developed muscular abdominal wall. Adhesions between loops of bowel and irreducible hernia render the intestine less mobile or, in the latter instance, immobile, thus fixing it for injury. Any disease of the bowel wall itself would weaken it and make it more susceptible to injury.

Pathology: The bowel wall is usually torn through all its layers. The tear is more often transverse than longitudinal. Occasionally just a small round hole is found. These tears involving the entire thickness of the intestinal wall may be called complete tears. If the tear only extends through the serous or outer muscle coat it is an incomplete tear. Very often there is simply a contusion of the bowel wall with marked ecchymosis. This may result in a rupture two or three days after injury. In seven to sixteen percent of the cases the mesentery is torn. In one of the cases herein reported there was a hole in the greater omentum. There is usually an extravasation of blood between the layers of the mesentery. Both large and small intestine may be involved.

Leakage with peritoneal soiling occurs in almost all cases. However, a small rent may be plugged by pouting mucous membrane, or by the intra-abdominal pressure keeping the injured gut tightly against adjacent loops.

Gage in 1902 collected eighty-five cases; seventy-five percent of these were due to the kick of a horse or man (the automobile has been a worthy successor). Of this number ten were perforations in the duodenum, twenty in the jejunum, forty-two in the ileum, and six in the large bowel. Chavasse collected 106 cases of rupture of the jejunum and ileum, nineteen of the large intestine, seven in the duodenum, seven in both large and small bowel, and one in the upper rectum. Makins points out that the portion of gut most apt to be injured is that hanging low in the pelvis, because it is most easily squeezed against bone here.

I wish to mention in passing the condition known as pneumatic rupture of the bowel, which occurs as a result of introducing compressed air into the rectum. A great many cases have been reported in the literature, most of them the results of jokes or pranks. Multiple rupture of the bowel is the result in a great many of such cases.

Symptoms: Most patients are in varying degrees of shock. However, there may be no symptoms at all for a period of one to three hours or more, and the patient may return to his work after such an injury. The temperature is subnormal, the pulse is slow at first, then rapid and of high tension. The patient is pale, and his skin is cold and somewhat clammy. He answers questions quickly, but volunteers no information. The respiration is costal in type, it is rapid and slightly labored.

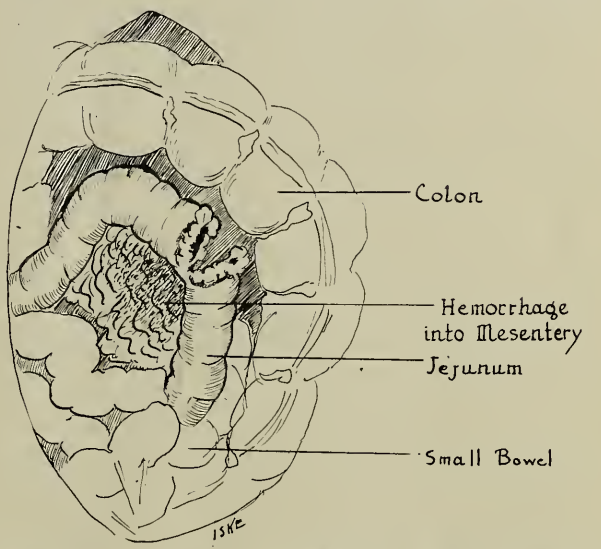


Illustration 1. Diagram showing tear in jejunum (case 2).

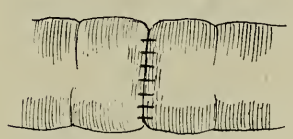


Illustration 2. Closure of tear in the manner of an end-to-end anastomosis.

There is vomiting, which is bloody at first, then stercoraceous. The tongue is dry. Great thirst exists. Bloody stools are not seen early enough to be of value in diagnosis. There may be diarrhea or constipation. The white blood count is elevated, usually to 15,000 or 20,000.

The abdominal wall may not even have a contused mark, or it may be only slightly bruised. The injury to the abdominal wall is not in any way indicative of the intra-abdominal damage.

The patient complains of great pain in the abdomen, and this is often referred to the back. At first the belly is not distended, and is usually flat, the muscles are extremely rigid. However, if there is marked intra-abdominal hemorrhage, this rigidity is not nearly so board-like. Obviously there is great tenderness on pressure. Later there is increasing distension as the peritoneum is soiled, and peritonitis with its concomitant picture develops in twelve to twenty-four hours.

Treatment: Immediate exploration must be done, if we would save our patient's life. Time is

an important factor, for the sooner operation is performed, the more favorable is the prognosis. We must not, however, in our eagerness to operate lose sight of the patient's general condition, and we must institute measures to bring about a reaction from shock. An intravenous of normal saline solution is given while the patient is being operated. He is kept warm by blankets before, during, and after operation. Stimulants are given if required. Donors are secured, and if hemorrhage has been profuse, transfusion should be done at once.

An incision is made in the mid-line below the umbilicus as a rule. If hemorrhage is present it must be checked. Then starting at a fixed point, the entire gastro-intestinal tract should be searched carefully. Even though we find one hole we must make sure there are no more. The rent is sutured by Halstead or Lembert sutures, and turned in by linen or silk. If the mesentery is torn it must be sutured. If a terminal vessel is torn and a portion of gut will thereby remain devoid of blood supply, resection with an anastomosis should be done, provided the patient's condition permits. If not, enterostomy is done by bringing a loop of bowel up to the belly wall. This can be closed later.

If the patient is operated soon after the accident, the abdomen is washed out with large amounts of warm normal salt solution according to the advice of Finney. A great many surgeons believe that liquids which soil the peritoneum are not as likely to produce peritonitis as are small solid particles, such as bits of food, etc. Whether or not one is able completely to wash these particles out is questionable. However, no harm is done by this flushing, since the case is early, and it should be done. If late and a beginning peritonitis is present, do not wash off the protective lymph exudate. If marked distension is present in late cases, a Witzel enterostomy should be done. A suprapubic drain is inserted and the wound closed. The patient is put to bed in the semi-erect position as soon as he awakens, and a continuous proctoclysis of normal salt solution is started.

In 1887 Curtis collected 116 cases up to that time. None were operated and all died. Since 1887 Homer Gage collected eighty-five cases. Forty-five of these were not operated and all died. Forty were operated and seventeen recoverd. Eisendrath collected forty cases that were operated on with a mortality of fifty-two and five-tenths percent.

Prognosis: Other factors being equal, the cases operated on immediately give the best results. From all sources, we may say that cases operated upon within the first four hours have a mortality of sixteen and two-tenths percent. In five to eight hours the mortality jumps to forty-four and four-tenths percent. In nine to twelve hours it is sixty-three and six-tenths percent. After twelve hours it is seventy percent and over.

CASE REPORTS

I have had two cases in the past two years that I wish to report as examples of this condition.

Case 1: C. R., age fifteen, white, male, was admitted to the City Hospital on the 23rd of December, 1926, complaining of abdominal pain and tenderness and vomiting. Two days before admission the patient had what was termed a bilious attack, with pain in the epigastrium but no vomiting. He was constipated. He had had no chills but a slight amount of fever. At 5:30 a. m. on the day of admission the patient was riding on a bicycle to his work at the Western Union. He was struck by an automobile and knocked down but the car did not pass over his body. He was able to walk to his work, but about one hour later began vomiting, and the pain in his abdomen became worse. Vomiting continued and the abdomen began to swell and become painful throughout. There was one normal bowel movement. The boy was brought to the hospital at 6:30 p. m., thirteen hours after the accident.

The patient's pulse rate was 120, temperature 101.6, respiration 30. No injuries were apparent anywhere on his body, not even signs of a contusion. Head, neck, and chest were normal. Patient was not in shock. He had an anxious expression. He breathed entirely with his thorax. He was very thirsty and was in severe pain. The abdomen was distended and very rigid throughout. There was extreme tenderness over the entire abdomen. No shifting dullness. Borborygmy was absent. The urine was negative. White blood count was 23,000. A diagnosis of general peritonitis was made.

The patient was given an intravenous of normal salt solution during the operation and this was repeated later. Continuous proctoclysis was immediately started following the operation. A mid-line incision was made below the umbilicus. The whole abdominal cavity was filled with seropurulent fluid. The entire bowel was covered with a plastic exudate, matting loops of intestine together. There were pockets of pus in the pelvis. Thorough exploration was not attempted because of the patient's desperate condition. However, limited exploration did not reveal the cause of the peritonitis. Drainage tubes were inserted, and the abdomen was closed. The patient died shortly afterward and an autopsy was performed, which revealed an oval hole about the size of a dime in the lower jejunum. Around this hole were a few hemorrhagic areas. No other pathology was found to account for the peritonitis.

Case 2: D. R., white, male, age twelve, was admitted to the City Hospital on November 27, 1927, complaining of pain in the abdomen, nausea and vomiting. His illness began following an auto accident in which the patient was pinned against a cigar stand by an automobile which backed onto the pavement. This boy was brought to the hospital two hours after the accident.

The patient's temperature was 101, pulse 120, respiration 22. The boy was pale and anxious. He

did not complain of pain, and was apparently oblivious to his surroundings. He answered questions, but did not volunteer any information. He was cold and covered with a clammy perspiration. His pulse was weak. Nothing abnormal was found in an examination of the head, neck, and chest.

There was a small contused wound on the right side of the abdomen. The belly was scaphoid in type, was not distended, and was extremely rigid. There was an extreme point of tenderness just above the umbilicus. There was a contusion to the right forearm and left foot. His urine was normal, the white blood count was 18,000. A diagnosis of ruptured viscus was made.

The patient was surrounded with hot water bottles and blankets. Six hundred cc. of warm normal salt solution was given intravenously at once. Four hundred and fifty cc. more was given during the operation. Because of the location of the point of tenderness, a mid-line incision was made above the umbilicus. Free blood and bile stained fluid was found in the abdominal cavity. There was a plastic exudate and an intense congestion of the small bowel. A large transverse tear of the lower jejunum was found extending around the bowel. There was marked effusion of blood between the layers of the mesentery. A hole about the size of a half dollar was found in the portion of the greater omentum which covered the injured portion of the gut. The rent was closed in the manner of an end-to-end anastomosis, first using cat gut and then a Lembert suture of linen. The hole in the omentum was closed with cat gut. Careful exploration of the liver, spleen, kidneys, and the entire gastro-intestinal tract failed to reveal further injury. Two soft rubber dam drains were inserted and the abdomen closed. A proctoclysis of glucose and sodium bicarbonate was given after the operation and morphine was generously used. The patient made an uneventful recovery and was discharged from the hospital in two weeks.

SUMMARY

1. In all cases presenting abdominal symptoms such as have been described laparotomy must be done, even though occasionally the diagnosis of intestinal rupture may be erroneous.

2. The time element is extremely important. The earlier operation is performed, the better the prognosis.

3. The abdominal wall may show no external injuries whatever (as in Case 1).

4. A careful study of these cases reveals the early signs and symptoms—those of peritoneal shock (Case 2) and the later signs and symptoms —those of peritonitis (Case 1).

5. The first case is an example of rupture by oscillation, the second an example of rupture by compression.

6. Since the presentation of this paper the writer has had reports of some fifteen or twenty cases from colleagues. This only illustrates that the condition is not as uncommon as a review of the literature would lead one to suspect.

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ADEQUATE LABORATORY SERVICE IN A SMALL HOSPITAL*

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During the last few years the subject of adequate laboratory service has received considerable attention in the College of Surgeons, in pathological societies and in our medical journals. The fact is that competent clinical pathologists are becoming scarce, owing to the inadequate compensation in this branch of medicine. Physicians send their laboratory work to free state laboratories, or if done in a private laboratory or in a hospital laboratory the fees are objected to as being too high. Because of this dismal situation pathologists are turning to other lines of work, young men are not attracted to this specialty, and, as a further result, laboratory work is falling into the hands of lay technicians or becoming the toy of recent graduates while they build up a practice in some other line.

Fortunately the American Medical Association and the College of Surgeons recognized this condition, saw the need to correct it, and are taking steps to restore this medical specialty to its rightful place. The Council on Medical Education and Hospitals of the A. M. A., in order to raise the standard of work, has established supervision over clinical laboratories, has secured a complete list of clinical laboratories in the country, and has formulated a schedule of essential requirements by which laboratories may be judged and graded. By questionnaire it has obtained full information on all laboratories, and those laboratories whose personnel and equipment were such that their work and reports could be considered reliable were "approved by the Council." Each year this list of approved laboratories is revised and those laboratories are dropped that fail to keep up the standard of excellence, while others are added. This list now comprises 160 laboratories in the United

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States, and is published once a year in the *Journal of the A. M. A.* Physicians are urged by the Council to send their work to these approved laboratories to the end that they not only secure for their patients the best analyses possible, but also to best conserve the interests of the medical profession and to encourage clinical pathologists to higher standards of excellence. This list does not include hospital laboratories, but is confined solely to privately owned clinical laboratories, operated not by technicians or laymen but by clinical pathologists. Now a clinical pathologist, according to standards of the A. M. A. and the College of Surgeons, "must be a medical graduate who has had at least three years' training in general laboratory work and who devotes the major portion of his time to laboratory diagnosis."

The Council, I understand, expects in the near future to standardize hospital laboratories in somewhat the same manner. Of course the larger hospitals may be able to afford, and many of them do have, clinical pathologists that devote their whole time to the supervision and operation of the hospital laboratory. The smaller hospitals, however, and by that I mean those of less than one hundred beds, cannot well afford, even if available, clinical pathologists of their own. Every hospital, no matter what its size, should have a laboratory where at least the routine work, such as urine, sputum, blood counts, cultures and smears, may be done either by a technician, a nurse properly trained, or some member of the staff who is willing to do the work. It must be recognized that technicians, while they may be trained to do this work, cannot have the broad knowledge of the fundamentals of medicine that are so essential to interpret properly the results of laboratory work. The ever-widening circle of the application of laboratory methods to diagnosis demands the skill of those physicians especially trained in this work, the clinical pathologists.

How then may the small hospitals have the adequate laboratory service which is so essential to the proper care of their patients? The answer is simple. Let the technicians do the routine work, but the more complicated tests, performed at more or less infrequent intervals and requiring special apparatus, need not necessarily be done on the hospital premises but may be sent to the nearest clinical pathologist, who may act as consulting pathologist either officially or unofficially to the hospital laboratory and staff. It has been said that technicians may be trained to do the work, and that the physician can do his own interpretation. To this we must answer that just as a technician may not have the essential knowledge to be entrusted with the grave responsibility of the interpretation of all forms of laboratory determinations, just so, because of the multiplicity of knowledge that has to be mastered nowadays by the physician and surgeon in their own work, only a few of them can possess the time and the happy faculty of also keeping abreast of the advances in laboratory medicine. For indeed the proper evaluation of laboratory findings requires not only a broad knowledge of medicine, but of the constant application of the special knowledge of laboratory medicine lest it grow rusty.

The first and primary function of a hospital laboratory is to aid in correct diagnosis and treatment by furnishing chemical, bacteriological, serological and pathological service. As there are less than 800 clinical pathologists in the United States, and over 806 hospitals of one hundred bed capacity and over, to say nothing of the multitude of smaller hospitals; and, furthermore, as many of these 800 pathologists are operating private laboratories and are unwilling to submerge themselves in a hospital laboratory, it is obvious that the small hospital must, in view of this scarcity of clinical pathologists, arrange for such service, if they want it, by cooperation with the nearest clinical pathologist for as much of his services as their needs require. Thus it has become the practice all over the country for the clinical pathologist to act as consulting pathologist for the group of nearby hospitals, perhaps visiting the hospital laboratory occasionally for inspection and helpful supervision or by correspondence only, the technicians doing the routine work while the technical diagnostic procedures like tissues, blood chemistry, serology, etc., are sent to him on some suitable financial arrangement, either in the form of a flat fee per month, or on a hospital discount basis which is customarily twenty-five percent off his regular fees.

The complaint is often made that laboratory fees count up and make hospitalization expensive. It is true that hospitalization is expensive nowadays, but why, if it is necessary to cut any fees, should the laboratory be the goat? There is just as much justification for a hospital furnishing good laboratory work for the patient and charging for it as there is for an internist or surgeon charging good fees for his work. Perhaps even more so, for ofttimes on the laboratory diagnosis depends whether or not there shall be an operation and whether the operation be simple or radical. It surely adds to the reputation of a hospital to see to it that every entrant is properly studied, in order that a correct and complete diagnosis be made and proper treatment instituted. If the clinical pathologist must cut down the fees for his services in order that hospitalization be not so expensive, then why not the surgeon and internist and the other specialists cut down their fees in the same proportion and for the same reason? What is sauce for the goose should be sauce for the gander. Cheap laboratory service is an evil that is a decided stumbling block to scientific medicine.

Financing the hospital laboratory is always a problem. Various methods have been suggested:

1. To charge the patient for what he has in the way of laboratory service at regular rates.

which is a fair and equitable solution. If the patient is unable to pay full fees, let all parties connected with the case cut their fees in the same proportion.

2. To charge a flat fee of say $3.00 to each patient to cover routine laboratory work, and if special tests are required they should be paid for extra. This method is abused often by physicians ordering laboratory work in unnecessary quantity or quality.

3. Adding some small amount, say fifty cents, to the *per diem* rate of each hospital room, to take care of the laboratory fees. By this method patients are not bothered by the question of laboratory fees. There is of course a question as to the justice of thus making a patient who has little or no laboratory work help pay for those who do.

Whatever the method of financing laboratory work the hospital sees fit to adopt, the proposition of having adequate laboratory service then is just this: Any county hospital can find within easy working distance a competent clinical pathologist with whom arrangements can be made to supervise by mail or occasional visit the small hospital laboratory. In this way the clinical pathologist may supervise a number of hospitals, giving each whatever of his service and advice they require, the routine work to be done by technicians, and the less frequently asked for tests like serology, blood chemistry, animal innoculations, tissues, and other complicated tests that require more elaborate and technical apparatus may be sent to his laboratory by mail or messenger for their quick and accurate performance. In emergencies reports may be phoned.

In conclusion I will say that small outlying hospitals can thus, by proper financial arrangements, have as good laboratory service as the large ones, if they want it and are willing to give the necessary cooperation.

TRAUMATIC RUPTURE OF SPLEEN AND KIDNEY

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Case report: E. R. S., male, age twenty-one, was seen in a neighboring city on May 29, 1927, at 2 a. m. eleven and one-half hours after an auto accident in which he had been severely squeezed on the left side of the trunk. There were some abrasions on the left side of the abdomen and chest. The patient had passed bloody urine, was very pale, the abdomen was tender and somewhat distended. It was evident that the patient was in imminent danger of death from intra-abdominal hemorrhage, hence an immediate laparotomy was done. Expecting to find a rupture of the left kidney the incision was made at the outer border of the left rectus muscle. The peritoneal cavity was filled with blood which, it was at once discovered, came from a badly lacerated and crushed spleen which was removed piecemeal. Owing to the desperate condition of the patient, and there being no rent discovered in the peritoneum covering the left kidney, it was concluded that the hemorrhage was largely from the spleen and that it would be wiser to let the kidney wound care for itself. The wound was closed about a large cigarette drain to the pedicle. Normal saline was given intravenously.

The patient had a stormy convalescence with vomiting, high temperature, and later a mild infection of the wound. The vomiting seemed clearly to have been caused by the giving of a cathartic. On account of the profuse bloody serous discharge the dressing had to be changed several times, which probably accounts for the wound infection. The drain should have been removed at the end of forty-eight or seventy-two hours, but through a mistake was removed gradually, the removal being completed fourteen days after the operation. The high temperature immediately following the operation was due probably to absorption of the extravasated blood. At the present writing (nine and one-half months after the injury) the patient is fully recovered.

Comment: I have been able to find one splenectomy and nephrectomy for coincident gun-shot injury of these organs, and one similar procedure carried out for subcutaneous rupture of the spleen and left kidney—both successful.[1]

There are two points of rather unusual interest in the case reported here. First, there was evidently a rupture of the kidney, as evidenced by blood passed *per urethram*. The principal hemorrhage was, it seemed clear, within the abdomen. After the incision was made it at once became evident that the morcellation of the spleen was probably the chief source of the bleeding, and a hasty exploration revealed no gross lesion of the kidney and no rent in the peritoneum covering it. This opinion proved correct, for the urine cleared up entirely within forty-eight hours after the injury. Second, the character of the injury to the spleen was unusual; as above indicated, it was literally torn into bits so that several ligatures to the pedicles of the various bits were necessary. Several observers have noted a pyrexia after splenectomy which could not be accounted for by infection, and it may be that the loss of the spleen in this case had something to do with the fever. In this case the fever came too soon after operation to be due to infection. No permanent lesions follow splenectomy. The transient anemia and leucocytosis following splenectomy is more quickly recovered from in young people than in those older. Nothing new has developed concerning the effects of splenectomy of a normal spleen for more than twenty-five years.

It is probable from the numerous observations that have been made that the bone marrow and lymphatics take on the work of the spleen after its removal. In a few of the milder cases perhaps, deep sutures will control the hemorrhage satisfactorily, but in the majority of cases of traumatic

rupture of the spleen, splenectomy is the operation of choice.

Roeser[2] collected one hundred and thirty-five cases of rupture of the spleen, of which one hundred and four died, ninety without operation. Of thirty in whom the spleen was removed sixteen recovered—fifty-three percent. A large part of this mortality is undoubtedly due to delay in operating. The surgeon's job in a case of ruptured spleen is to stop the bleeding before it has reached the danger point. The keynote of success in these cases is prompt operation.

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OCCUPATIONAL THERAPY AND THE PRESCRIPTION*

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To use our definition of occupational therapy, it is any activity, mental or physical, definitely prescribed and guided for the distinct purpose of contributing to or hastening recovery from disease or injury. Therefore, we must of necessity start with the prescription written by the doctor in charge of the case. Until recently, in many hospitals, this prescription, so treasured by the therapist, oftentimes has been only an authorization or, I might say, merely permission to give a patient some occupation. This is by no means sufficient since the occupational therapist hopes actually to contribute something to the recovery or improvement of the patient during the convalescent period when so much can be done with the otherwise tedious hours of waiting.

The application of occupational therapy requires a complete knowledge of the individual patient, his social history, his mental status, his temperament, and most of all the character and extent of his disabilities. Consequently, for the successful practice of occupational therapy very close cooperation with the physician in attendance is essential. The therapist needs all the helpful suggestions as well as precautions, and the doctors' knowledge and judgment regarding the patient is the only real foundation on which she can build her work. Just as it is imperative that the occupational therapist has an intelligent conception of the medical conclusions and endeavors of the doctors, so then it is equally essential that the doctor have a thorough understanding of the possibilities of his occupational therapy department and in just what measures it is capable of assisting him in the common cause of physical or mental improvement.

Bedside occupations are considered important in that they are the first steps toward inspiring the will and developing concentration, as well as stimulating interest to carry on for what is to come later in a therapeutic way. This is the opportunity to learn the tendencies, the personal and social history—in other words, to gather up the data on which to base your program of progression. For these reasons we are no longer told that a cardiac is too sick to work, or a Bradford frame case isn't allowed to work, because we have proven that the cardiac expends less energy in supervised occupation than in restless idleness, and a frame or traction case twists and squirms about less when busy with some fascinating article under construction. We feel that these cases where our efforts are employed in preventing fatigue and exhaustion by relieving the causes of restlessness and irritability are just as therapeutic as the orthopedic cases wherein we can actually help to create and develop muscle strength and motion in joints. Diversional work for the child who is compelled to be in bed with a cast on for six to eight weeks is, to my mind, quite as therapeutic as any other, psychologically, at any rate.

Bedside occupations should be looked upon as a means to an end and their function primarily to prepare for the next step in the reconstruction program. Light manual occupations are employed because at times of general weakness any other kind of effort is impossible. At first the task must be very easy, the result definite, and the time of accomplishment short, in order to create an interest immediately, and then it becomes necessary to so grade the successive work that this interest will be stimulated continually.

No occupation is therapeutic in itself and only becomes so as it is selected and guided in relation to a particular disability. For instance, basketry when scientifically applied has many uses. It is given to an excitable or nervous child, in simple form, to bring about relaxation. The size, shape, and weight of the basket determines whether the movements involve the wrists, elbows, or shoulders. So large reeds and simple weaving are used for broad movements as the first step in developing coordination. Fingers which cannot manage a reed of ordinary size can firmly grasp one of larger diameter. Finer work can be substituted gradually as ability to coordinate increases.

In similar ways, toy making and wood work bring about exercises for the fingers, hands, arms, and shoulders, the various movements being produced by planing, sawing, hammering, and painting. A velocipede scroll saw operated by both feet with bicycle motion, and a foot-treadle saw with sewing machine action are used for desired motions of the ankles, knees, and hip.

Hand and foot power looms for fabric weaving are invaluable because they make possible the grading of exercise so as to involve any or all parts of the body, or one or more of the extremities. We have the tiny light-weight bedside looms requiring very little strength of fingers and arms; the heavier table looms operated by the hands only, but creating a wider scope of motion in arms

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and shoulders, and then the different sizes of treadle looms or foot power looms requiring the use of one or both hands and feet.

Plastersene, kiddie kars, games, and tricycles are useful equipment for small children, too young to be taught craft work. There are many other crafts adapted for the use of occupational therapy, but these mentioned have been generally approved because of the scope of motion, effort and concentration, as well as the variety of interests which they offer.

Posture while at work is always considered important and careful supervision prevents fatigue and strain of any kind. Postural exercises develop resistance against infection, as well as increasing chest expansion. Knotting with deep breathing exercises is a very effective therapeutic measure. With the patient either flat in bed in proper position or in correct sitting posture, by pulling the knots taut the back muscles are strengthened and those of the abdomen retracted, and deep breathing accompanies this exercise for the purpose of increasing chest expansion.

It might be well to cite a few typical cases wherein occupational therapy has been of significant assistance.

A girl, thirteen years of age with a diagnosis of anterior poliomyelitis, had stabilization of left foot and cast on leg for four months. The leg was at full extension during this time and she was entirely unable to bend her knee when the cast was removed. Occupational therapy was prescribed for the purpose of restoring motion in the knee. Foot loom weaving was given as a means of exercising leg muscles until strong enough to produce motion in knee joint. The child was started with five-minute periods and the time gradually increased. She showed marked improvement in flexion of knee from day to day. This is the type of case in which occupational therapy can be of valuable assistance in teaching children to walk again after long inactivity.

A girl, eight years of age, with diagnosis of subacute endocarditis, was critically ill on admission to hospital. After several weeks with patient still in Fowler position, occupational therapy for very short periods was prescribed for the purpose of adjusting the child to more normal activity and giving mental stimulus. She was given very light basketry at first in five-minute periods and type of work and time gradually increased. The doctor noted that during the two weeks immediately after the occupational therapy treatments were started the child was markedly better, and had no sick days as had been the case previous to this time. Now this child works a full hour at light occupations without fatigue.

A child, thirteen years of age, with a scoliosis, was obliged to lie on a Bradford frame in a cast. Knotting was used in this case for the purpose of strengthening the back muscles while they were in the proper position.

For a boy, twelve years of age, recovering from acute rheumatic fever, occupational therapy was prescribed to exercise joints that were becoming stiff. Basketry was used for finger, wrist, and elbow motions, and as the child had been very ill he was consequently irritable, so the mental stimulus of the work in this case was considerable.

A little girl, eight years of age, with a diagnosis of chronic infectious arthritis, had occupational therapy prescribed for stiffened wrists and elbows. Basketry with high spokes to reach up to and long reeds for weaving brought about the desired extension of elbows as well as increased motion in wrists and shoulders.

So it is evident that we do not make a basket for its intrinsic worth, or a woven cover for its artistic satisfaction as a textile, but rather for its value as a remedial measure in the treatment of the patient. For this reason it is necessary that we have in our prescription a complete statement of the result desired by the doctor, whether it be increased motion in a joint, strength in a muscle group, or improved mental attitude. Then, of course, his close cooperation and supervision must follow.

THE EARLY DIAGNOSIS OF PULMONARY TUBERCULOSIS*

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As the universality and prevalence of sin in this world always afford the preacher a perennial topic for his sermons on the salvation of the sinner, so likewise the universality and prevalence of tuberculosis render the consideration of the early recognition and cure of the disease always timely. In either case, it is a plea to flee from the wrath to come, whether from the penalties of sin or the results of a delayed diagnosis. Every physician has witnessed the tragedy of an unrecognized and untreated case of tuberculosis, and it is to avert such a disaster that we keep insisting so much upon the early diagnosis, not that one can present any new methods for making an early diagnosis but perhaps can present the old methods in a new light.

There are two main reasons why an early diagnosis is not made: first, because the individual suffering from early active tuberculosis does not consult a physician until the disease has passed beyond the initial stage. He does not think he is ill enough to consult any physician. And second, because the physician, for one cause or another, fails to detect the disease when it exists. It has also, on the other hand, not infrequently been my experience that cases have been referred to me with a diagnosis of early tuberculosis from an incorrect interpretation of symptoms or the existence of supposed physical signs, when on careful examination no disease has been found. It is a serious matter to upset one's whole plan of life on

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a mistaken diagnosis, particularly of the "dreaded tuberculosis."

No one, obviously, in his ordinary health consults the doctor. It is only when some unusual symptom occurs which alarms him or renders him uncomfortable that he does this. In the case of pulmonary tuberculosis, there are various symptoms which the patient as well as the physician has learned to associate with possible tuberculosis. Spitting of blood invariably sends the patient post-haste to the doctor, although it does not always, but almost always, denote pulmonary tuberculosis, and even then, not always active tuberculosis or followed by active disease. A long drawn-out "cold" or cough, loss of appetite and digestive disturbances are suggestive symptoms. I recall very vividly the case of a young woman who complained only of loss of appetite and digestive disturbances in which I failed to investigate the possibility of tuberculosis, and which subsequently proved to be the real cause of the symptoms. Other symptoms are loss of weight and strength, or increasing fatigue. One, for example, complains of being always tired on going to bed and on getting up and all through the day. With women, cessation or intermission of the menstrual period is again a suspicious symptom. No one of these symptoms may be caused by an active tuberculosis, not even hemoptysis, but they are highly suggestive and call for a careful investigation. Again, a case of neurasthenia may in reality be the result of a tuberculous toxemia. In other cases, no especial symptoms may be complained of, and yet the patient consults the doctor because he does not feel in his usual health, the reason why he cannot tell. Here again, tuberculous toxemia may be the cause and a careful examination is demanded.

I do not place much confidence in the family history. The statements of the patient are more or less uncertain or hearsay. I cannot see that it makes very much difference what one's ancestors or relatives died of in collecting the evidence for a diagnosis.

The *past history* of the patient, on the other hand, is most important. What we want to know is the general health history of his life from the cradle to the present moment. Has he been a "contact" case? What children's diseases has he had, particularly pertussis and whooping cough? For these diseases are prone to leave the lungs in a susceptible condition. How has he lived during his childhood and adult life? Has he worked under wholesome conditions? Has he been exposed to mineral or metallic dust? Has he had sufficient rest and sleep and proper nourishment? In brief, we want to find out any event or habit in his life that may have a bearing on his present condition. All this information should be obtained by the physician himself and not through his secretary or nurse, for in eliciting it the physician has a good opportunity to observe his patient closely both as to his physical appearance and his mentality and honesty, as it is a curious psychological phenomenon that a patient will prevaricate in his statements and answers in the hope of obtaining a favorable diagnosis.

After the past history has been obtained, the immediate cause of the patient's visit to his physician is investigated, be it an hemoptysis, prolonged cold, or some other of the symptoms mentioned above. Naturally, some of these facts will be obtained in eliciting the past history.

In the physical examination, the patient is seated on a revolving stool and before a good light, stripped to the waist with a warm blanket thrown about him. It is well to remember that whatever one finds in the physical examination does not, of itself, always indicate active tuberculosis. There must also be symptoms. Physical signs without symptoms only indicate a tuberculous infection or an old fibrosis. and conversely, symptoms without discoverable physical signs may and often do unmistakably indicate active disease. Inspection of the chest is going on all the time of the examination. The size and shape of the chest, and its movements in respiration are noted, whether one side moves more freely than the other, or whether there is more depression above one clavicle than above the other, and anything else abnormal is noted. Unless the patient has a clear, rather low-toned voice, tactile fremitus will be of very little, if any, aid. The more one's ear is attuned to fine differences in musical notes, the more he will get out of percussion and auscultation. Laennec played the flute; Auenbrugger was devoted to symphony music; and Flint played the violin. And again, the more one familiarizes himself with the normal sounds elicited in percussion and auscultation, the better will he detect abnormal ones.

In early diagnosis very little, if any, information will be obtained from percussion. Definitely recognized dullness means more than a slight lesion. Slight differences in resonance are difficult to detect and there is always a doubt as to their real existence. It is always to be remembered that, normally, at the right apex there is slight comparative dullness, as there is harsher respiration, than at the left apex.

It is chiefly upon auscultation that one must depend for physical signs, if indeed any are to be found at all. Such signs will be either in the character of respiration or rales. We may be able to distinguish some change in the respiratory murmur. The respiration may be noticeably diminished and it may be rough (broncho-vesicular) with a prolonged expiratory murmur. Bronchial respiration indicates a more advanced case. If one is at a loss to distinguish between bronchial and vesicular respiration, he has only to place his stethoscope under the lobe of the ear to obtain a good example of bronchial respiration. To be sure of slight modifications of the respiratory sound is difficult and one is often in doubt as to whether they really exist or not. Our main reliance is upon the finding

of *persistent* fine rales at one or the other apex. They are by far the most significant of auscultatory signs for they are definitely abnormal, and when found, experience has taught us that they are almost pathognomonic of tuberculosis, but not always of an active tuberculosis, unless there are at the same time symptoms. The finding of rales *only at the base* of the lungs does not have, or only rarely has, the same significance as rales at the apex. One must agree with Hector MacKenzie's dictum that "the earliest physical sign which is really characteristic is the presence of rales." To find persistent fine rales at one or the other apex is a "saving grace" in the early diagnosis of tuberculosis. But to elicit them, one must not forget to have the patient *cough*. The best way to do this is to ask him to take a full inspiration, then expire and near or at the end of expiration to cough, and then quickly inspire again.

The temperature and pulse are important factors. The temperature, unless definitely a fever temperature, is not of much importance when taken *once*. The patient should be told to get a thermometer and take his temperature three times a day for a week. A constant afternoon temperature of 99.5 degrees or above and a pulse of 90-100 are very suspicious at least.

In the early diagnosis, one will probably *not* find tubercle bacilli in the sputum, for the tuberculous focus has not yet connected itself with a bronchus. The sputum should, however, be examined *several times*.

The x-ray, if it is accessible, is of course a very great aid to the physician, but he should not allow it to make the diagnosis for him. It should only be regarded as another piece of important evidence. Says Holmes, one of the most experienced x-ray specialists, "The demarcation between the normal and the pathological is not sharp and it takes considerable experience in the observation of plates combined with all that can be found by clinical methods to establish a correct diagnosis." The x-ray is not a necessity and it may be misleading, and one should not throw the burden of proof of an early diagnosis upon the roentgenologist. No one, not even the specialist, can make a diagnosis of early tuberculosis at the first visit. The only thing to do is to keep the patient under observation and wait for more evidence. It takes time and care to make an early diagnosis. An hour should be allowed for it, but one is well satisfied if at the time of the examination either a positive or negative result is obtained.

In conclusion, the steps to be taken in making an early diagnosis are:

1. A careful past history of the patient.
2. A careful consideration of the patient's condition and symptoms.
3. A physical examination, including weight, pulse, and temperature.
4. Examination of the sputum.
5. X-ray examination when accessible.

SPECIAL ARTICLE

ANNUAL HEALTH AUDITS*

The medical profession is not backing the periodic health examination movement to advance its own interest but to add years to the life of every individual American citizen. An earnest effort is being made to impress the physicians of Indiana as well as the public with the importance of periodic health examinations. The Indiana State Medical Association has endorsed the movement of keeping health records and through its Bureau of Publicity is giving, where requested, demonstrations to medical societies upon the thorough method of giving these examinations.

In consequence, considerable interest has been aroused among the physicians on this question and the Indiana State Medical Association desires to stimulate this interest in every way possible.

A manual for the conduct of periodic examinations published by the American Medical Association for physicians says: "The average adult accepts certain tendencies such as overweight, constipation, premature baldness or flat feet as predetermined and beyond his control and has resigned himself to these conditions. This attitude of resignation and acceptance of limitations is entirely out of accord with the present-day demand for efficiency. The human machine is coming in for its share of study and the physician is the efficiency expert who must direct the service. This means that physicians, in addition to caring for the sick, must assume responsibility for the instruction of the supposedly well in such details of hygiene as will prevent them from developing illness."

Thousands of dollars are being spent by various agencies to persuade people to do the sensible thing and be examined and to prepare the general practitioner to make these health examinations. The medical profession is using every dignified method available to sell the proposition to the public and to the family doctor, the man who will have to do the job.

Who is back of the movement? Practically every agency and organization interested in the health of the public: the American Medical Association, the National Tuberculosis Association, the American Red Cross, the Gorgas Memorial Association, the National Health Council, representing more than a score of health groups, life insurance companies, health departments, hospitals, industrial concerns, individual physicians and practically every official and voluntary health agency in the country has advocated periodic health examinations.

*This article is prepared by the Bureau of Publicity of the Indiana State Medical Association and is published at the request of the Bureau. This is the second of a series of four bulletins prepared by the Bureau upon the subject of periodic health examinations.

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Devoted to the Interests of the Medical Profession of Indiana
ALBERT E. BULSON, JR., B.S., M.D., F.A.C.S.
Editor and Manager

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EDITORIALS

VENTILATING AND DRAINING NASAL SINUSES

We quite agree with Dr. Emerson, who in last month's issue of THE JOURNAL says that most patients who catch cold easily are, in fact, merely suffering with exacerbations of a pre-existing cold. In other words, there is a focus of infection in the sinuses which may remain quiet for months and then flares up, later to subside, and still later to flare up again. It is possible that the trouble may be a visible nasal lesion or bad tonsils, but more often it is an infected sinus. Furthermore, it is these dormant infections in the sinuses which are responsible for a variety of symptoms and constitutional disturbances which bring the patient to the internist for relief, and which do require the services of the rhinologist. Dr. Emerson indicates, and he could have emphasized more strongly, the fact that ventilation and drainage in these cases, accomplished through conservative surgery, does wonders. Every rhinologist of experience and training who has ventilated and drained diseased sinuses for his patients has noted the marked and oftentimes miraculous benefit secured for the patient. There has been a tendency on the part of a few internists to discredit the effects of sinus surgery, and perhaps in every instance objection is based upon an isolated instance where, as a result of failure to ventilate and drain all of the diseased areas, including areas remote from the nasal sinuses, the result has not been as favorable as expected. It is refreshing to know that one of our leading internists has taken such a broad view of the subject and not only endorsed the stand taken by rhinologists that diseased accessory sinuses are better off if ventilated and drained than when let alone, but has gone a step further by advocating attention to the sinuses when perhaps the rhinologist has *not* found sufficient indication for surgical treatment. He also might have called attention to pressure symptoms from septal deviations and spurs which a well executed submucous resection relieves and usually with marked appreciation on the part of the patient. We are opposed to the mutilating surgery that is sometimes performed in the interest of better breathing or to relieve pressure symptoms, but we do believe that judicious and well-executed intranasal surgery, including drainage and ventilation of accessory sinuses, where indicated, can be made of great benefit to the patient and of assistance to the internist who may be called upon to treat conditions that are dependent upon such lesions.

THE MEDICAL EXPERT

So much has been said concerning medical testimony in courts of law and its varying value that it would seem that little more can be said on the subject, though the correction of the evils that seem to exist in present-day court procedures as pertaining to medical evidence is worthy of serious consideration. It has been our contention that expert medical testimony should be procured and compensated for by the court, with the distinct object in view of getting an impartial opinion and one not dependent upon the fee paid by prosecution or defense. In a very large measure this plan ought to do away with the charge that medical testimony can be purchased or, to put it less bluntly, that medical testimony is apt to be biased because of the fee and the implied duty of the witness to testify in accordance with the ideas of the one who is paying the fee for the testimony. We are not willing to admit that medical men are any more dishonest than men following other vocations, nor that they are any more willing to testify to facts or opinions which favor a certain side merely because they are paid for doing so. In fact, as Sweeney, in a recent article in *Minnesota Medicine* for March, 1928, well says in his discussion of the subject, "Honesty is an individual rather than a professional trait. Neither do the opinions of medical men vary so widely as compared to the opinions of lawyers and others." Concerning varying opinions Sweeney cites the instance where in the case of a murder which took place in a butcher shop in the month of February when the thermometer registered between twenty and thirty degrees below zero, five witnesses who passed the butcher shop testified in court that on that date they saw through the windows certain persons in the shop. The defense brought six witnesses who swore that they passed the place at the same hour and that the windows were so completely covered with frost that nothing inside was visible. Therefore, since the memory and observation of *concrete* events is so full of contradiction, why are our lawyer friends so sneering and sarcastic when two physicians differ on *abstract* matters?

The title, "medical expert," is a misnomer, for in a court of law a physician is an expert because he admits it, when, as Sweeney says, the courts are bound to accept this self-laudation as a fact, and with unending gravity the judge, just as if he didn't see the joke, permits the most ignorant medical ass to give his opinions to the jury with the same weight as if Hippocrates himself were talking. In fact, in those states where chiropractors are licensed to practice, the members and leaders have arrived at the dignity of medical experts, and the occupation of chiropractor, being

recognized by law, has a standing in court not inferior to that of the medical man. Thus they glibly talk of subluxation, dislocation of vertebræ, impingements on nerves and other absurd pathology as the cause of neurasthenia, hysteria and cerebral hemorrhage, and the jury takes it all with the same weight as the opinions of physicians. Doctors look alike to a blind man and so far as the juror is able to distinguish between the various schools of practice he might as well be blind. All experts are the same to the juror.

Sweeney makes a plea for the abandonment of the misleading term of expert medical witness and substitutes for it the logical term of medical witness. The average jury gives little weight to medical testimony anyway, and particularly if there is any variance in the opinion expressed by the medical witnesses. Most juries are decidedly inferior in intelligence, and technical medical testimony goes entirely over their heads. They also are very apt to be guided by emotions, sometimes sympathy, and at other times by prejudice or resentment, especially if there is a charge of neglect on the part of some so-called "soulless corporation." If the medical witness is too technical his testimony goes for naught with the jury. Furthermore, if as a result of the cross-questioning he becomes combative, excited, or confused, he also loses out with the jury. The greatest fault of the medical witness is his tendency to talk over the heads of the jury. Oftentimes medical testimony is ineffective because of the tendency of juries to become so confused between conflicting opinions that they must disregard it. The remedy, as pointed out by Sweeney, is the exercise of more professional honesty and a greater capacity for the physician to express his opinions intelligently and clearly, with due recognition of the fact that the average jurymen are mentally juvenile and one must talk down to their level of comprehension.

HAS PSYCHIATRY ADVANCED?

"The Frail Sister of Medicine" is the title of a leading article in the May number of *The American Mercury*, by Ralph Coghlan, and in it the argument is advanced that psychiatry has not advanced since the dark ages, and that despite innumerable theories and all of the study and investigation that has been made, we have made no real advance in the discovery of the cause of mental disease. The author says, "For all we really know of insanity today, the old belief that a man insane is a man possessed of devils is just as plausible as any theory which has been offered since. The whole tribe of psychiatrists seem to be in vast confusion. All of the many theories that have been advanced have either been exploded, or their pursuit has been abandoned. Fads succeed one another nowadays in kaleidoscopic patterns, and the gentlemen of the profession, torn by their conflicting views, can find no converging point. * * * Though mental disease is one of the greatest scourges of mankind, no one leaves any money for its study, the medical schools neglect it, and the effort to cure it is confined to a relatively small number of men who seemingly have not the time, the money nor the inclination to go deeply into it. The ordinary physician knows practically nothing about it, and a good many so-called psychiatrists are simply political doctors who happen to have got themselves appointed to the superintendencies of public insane hospitals.

"I know of no better way to illustrate this condition in psychiatry than to refer to the familiar antics of its practitioners in criminal trials. It is a truism to say that it is possible to find an expert to contradict and, indeed, refute the testimony of any other expert as to the mental state of any given defendant. In almost any criminal trial where the plea of insanity is made this is what happens, reduced to the exactitude of a mathematical formula: 'All the psychiatrists hired by the defense solemnly swear that the defendant is insane. All the psychiatrists employed by the state swear with equal solemnity that the defendant is sane.' Is there any other scientific field in which conclusions drawn from the same sets of facts are so ludicrously antagonistic?"

The author then goes on to say that the most notable exhibition of the muddled state of psychiatric science in recent years is provided by the evidence in the Loeb-Leopold case in Chicago. It is proverbially true that the so-called medical expert takes the case of the side that employs him and does the best he can. If he is not willing to testify to certain facts or theories, he is not employed by the side that wishes to establish those facts or theories. As Clarence Darrow has well said, "Of course, scientific men do not need to be told that the receipt or expectation of a fee is not conducive to arriving at scientific results."

The author then says, "Is it any wonder that the public, witnessing such fights as the battle of these experts (such as occurred in the Loeb-Leopold trial) should get the impression that psychiatry has sunk to the level of chiropractic? * * * The tendency now is to call the insane sick, and, instead of chucking them into asylums, we put them into hospitals for treatment. In fact, the psychiatrists say that instead of being tried in courts of law for their crimes, so-called criminals should be turned over to experts for 'treatment. But who are the experts? And to what group of theorists ought we to turn for relief?"

In conclusion, the author says that, "What is needed in psychiatry is more research and less ballyhoo, more work in laboratory and clinic and less in courtrooms and legislative lobby. The most dreadful thing that could happen to the science of psychiatry as it stands is for society to admit its pretensions and ask it to take over the whole problem of the insane and the criminal. Such an act would strip it of its gauds and baubles and exhibit it as what it is: a very young and still

incompetent science, advanced not very far beyond where it was left by Hippocrates."

REGULATING CHARITY MEDICAL SERVICE

We have received numerous inquiries as to what solution is offered for the increasing problem of regulating the furnishing of gratuitous medical and surgical services to the deserving poor, and the abuses of medical charity as now exist.

It appears to us that the medical profession, as a profession, must take more interest in the subject of who is to receive medical charity, where it shall be rendered, and the kind of service that will be rendered. In our metropolitan centers, where there are teaching institutions and clinics maintained primarily for the benefit of the teaching institutions, the problem is solved, though even in such places there is room for supervision of much of the charity medical service that is now dominated and controlled by various *lay* welfare organizations. Of special interest to perhaps a majority of the medical men is the problem as it confronts the smaller cities and even the towns. Not only is constructive work necessary in these places, but there must be developed a spirit of harmony and cooperation in the medical profession that will result in a satisfactory and effectual operation of any plan that is adopted. Some physicians have advocated, and with considerable reason, that inasmuch as practically every community now has its hospital or hospitals, it would be an easy matter for the staffs of such hospitals to inaugurate a system of medical welfare work, under the direct supervision and control of the staff, to the end that all deserving cases of whatever nationality, class or creed shall receive adequate and competent service. In carrying out the plans the various lay charity and benevolent associations or individual welfare workers should be notified to the effect that the hospital staff or the medical and surgical charity organization of the staff, stands ready to render any and all needed service to the needy, gratuitously if indicated, or at such fees as shall not be a hardship for the patient. Each and every case submitted for such service must be investigated and satisfactory proof furnished showing that the services of the organization are justified. A possible objection to such a plan might be the possibility of rivalry between the staffs of different institutions, or the charge, perhaps unfounded, that the charity work will be used as a feeder for the hospital or the physicians comprising the staff of the hospital.

Another plan suggested, and one that seems to us more appropriate, is that which requires the formation of a welfare clinic by the medical society of the individual community, such welfare clinic to be manned by the members of the society who perhaps can serve in rotation or in accordance with some system whereby the burden is evenly distributed and each member required to do his proportionate share. The management of the enterprise, and in fact all that pertains to its policies, should be under the jurisdiction and control of the medical society. Such a welfare clinic could be conducted at a central location, either in connection with or apart from the hospital, and the fund for the actual expenses, together with the cost of hospitalization of cases, should be borne by lay welfare organizations who care to contribute in matching the generosity of medical men. Some such plan as proposed, if carried into effect, would put a stop to much of the undeserved charity that is bestowed by various individuals and enterprises that have not analyzed the conditions presented.

In the interest of society, there would be less encouragement of dependency and pauperism, to say nothing of the loss of self-respect on the part of those individuals who are willing to accept and even ask for something for nothing, if medical charity was organized and put under control of physicians.

PAYING FOR MEDICO-LEGAL DEFENSE

The medical defense committee of our Association has been having a friendly controversy concerning the payment of a bill presented by one of its members for legal services rendered in a malpractice suit in which the Association had little voice. As a matter of fact the member was entitled to the defense at the expense of the Association providing he followed the rules and regulations governing such matters. The member puts up the argument that being the one most interested he should be privileged to select his own attorneys and be guided by his own judgment and the advice of his attorneys as to the conduct of his case. On the other hand, the medical defense committee takes the stand that if the Association is to pay the expenses of medical defense, then the Association has an interest in the case and is entitled to a voice in the arrangements for that defense, including some voice in the selection of attorneys and the amount of their compensation. Attention is called to this matter primarily for the purpose of reminding all the members of the Association that while seventy-five cents per year *does* entitle *members in good standing* to medico-legal defense, yet that service is furnished under perfectly fair rules and regulations that must be followed in every instance. The Association reserves the right to object to the selection of attorneys who are either incapable or are not willing to serve except upon the payment of extortionate fees. In a few instances the Association has been "stung" for attorney's fees that were little short of robbery. Such experiences have resulted in the adoption of definite rules and procedures, among which is an understanding in advance as to what is to be paid for the legal service rendered in any individual case. If any member of our Association is sued or threatened with suit for malpractice, he should not lose his

head and consult a lawyer at once, but get in touch with the Association office for some helpful suggestions and advice which will be given him promptly. If entitled to defense by the Association that defense will be provided, and the matter of the selection of attorneys and the compensation to be awarded them will be settled to the satisfaction of the member as well as the Association.

DONATING MEDICAL SERVICES

When it comes down to donating valuable services, without money and without price, the medical man registers one hundred percent. Everyone else can charge for his services when it comes to welfare or uplift work, but the physician is expected to give his services, technical and valuable though they be, without hope of remuneration. This is all right if the health clinics and other welfare work requiring the services of a physician are for the indigent, but it is all wrong when the valuable services are rendered to those able to pay. A well-known physician who was contributing a day of his busy life to a baby clinic, and getting nothing for it, was dumfounded when he noted that a half dozen children from well-to-do families that he considered as his patrons were brought to the clinic for free service, and in addition were scheduled for free service at an operative clinic. You hear someone say that health is a community asset that must be conserved, and it is up to the community to aid in the promotion of health. Granted! But clothing and food are necessary for the preservation of health, but do you see any clothing merchants donating clothing to cover naked children, or can you get any photographs of food merchants who are donating food for starving children? No! The benevolent and charitable organizations pay for clothing and food which they donate to the indigent and poor, but they do not expect to pay for any medical service, no matter how valuable such service may be. Probably no reputable physician anywhere in this country refuses to render professional aid to the indigent and poor, but he has a right to complain bitterly when his generosity and charity are imposed upon, and that is exactly what is going on every day in every populous community. There are too many so-called welfare organizations that are asking for gratuitous services from physicians, and it is time for the medical profession to insist that a good deal of this welfare work done by volunteer organizations should be in the hands of organized charity with the medical profession having a voice in the manner in which gratuitous medical services shall be rendered.

Quackery reminds us of fake oil or mining stock. It usually blatantly promises big returns, but eventually proves a total loss to the investor. Unfortunately there are too many people who do not investigate before they invest.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

Don't forget this year's annual session of the American Medical Association at Minneapolis, June 11 to 15, inclusive.

Vacation time is coming and every physician should preach the doctrine of prevention of typhoid by typhoid vaccination. It is not too early to talk about the matter to the public.

The A. M. A. meets in Minneapolis this year. The dates are June 11 to 15, inclusive. You had better go! Three railroads offering excellent service from Chicago have advertised in The Journal. They are trying to make the trip to Minneapolis especially attractive to physicians.

If any physician in Indiana has been asked to subscribe for a book called the "Social Register of Indiana" we suggest that he follow the injunction often given in this journal to "Investigate before you invest."

A coroner is a very important officer, but to look at some of the uneducated and illy-trained men who are seeking the office, one would think the position of no more importance than that of grave digger in a country churchyard.

On every hand we are hearing about the wonderful results secured from the use of the ultraviolet ray. Much of the propaganda is pure bunk, and physicians should not be taken in by it, nor should they permit the public to be victimized.

The Kirkpatrick treatment for tuberculosis, heralded from Portland, Oregon, has been analyzed by the A. M. A. and found to be essentially a weak solution of potassium iodide. The iodides are not valuable in the treatment of tuberculosis, and in fact may be dangerous.

The Koch Cancer Cure must be a profitable enterprise, for according to the published statement the *Bulletin* is sent out at an expense of nearly six thousand dollars per issue. In the final analysis, cancer dupes pay this expense as well as a handsome profit to Koch and his followers.

RESERVATIONS for the Gary session should be made at an early date. These should be made through the hotels, direct. However, the local society has a hotel committee, of which H. M. English, 607 Broadway, Gary, is chairman. Dr. English will make reservations for you if you wish.

WE talk a good deal about periodic health examinations but just how many physicians are supporting the enterprise? Incidentally, we would like to take a poll of the medical men of the state and find out just how many of them have had a thorough physical examination during the past year or two.

As an evidence of the folly of licensing members of the pseudo-medical cults, we cite the death of a patient from pneumonia while under the care of a chiropractor who did not know the nature of the disease for which he was giving treatment. What a farce our licensure is when it does not require knowledge of how to diagnose disease.

SOME physicians are writing prescriptions for heroin, though why we do not know. It would be well for them to take into consideration the fact that by action of Congress both the manufacture and sale of heroin have been prohibited. If a prescription for heroin is filled by any druggist it is a fairly safe bet that a substitute has been used.

THOSE who have been in touch with the development of the University Medical School and Hospital at Indianapolis are sorry to learn that Robert E. Neff, the administrative officer for these enterprises, has resigned to take up a position in Iowa. Mr. Neff is very efficient in every way and it will be difficult to find his equal to fill the position he has vacated.

NOT a month passes that we do not find numerous exchanges quoting THE JOURNAL and usually giving us credit. Occasionally a medical journal copies our editorials or editorial notes and gives no credit. We appreciate the compliment in quoting THE JOURNAL but would feel a little better about it if an editor were not trying to palm off some of our stuff as his own.

AN Akron oculist has determined through retinoscopy that race horses, to the extent of about ten percent, have defective vision which may be corrected by glasses. He has had lenses ground according to the requirements and mounted in special blinders, and according to all reports the animals have not objected to the glasses but have given indication of being able to see better.

THOSE who attend the coming session of the A. M. A. can secure one and one-half fare rates for the round trip to Minneapolis. When buying a ticket to Minneapolis ask the ticket agent to furnish a certificate which, when certified and validated in Minneapolis, will entitle the holder to purchase his return ticket to his home over the same route traveled to Minneapolis at one-half fare.

FRUIT enters so largely into the diet of the average individual that it is well to remember that it is not the largest and handsomest fruit that ranks first in taste. This is true of apples, oranges, pears, peaches and many oher fruits that might be mentioned. As an explanation it is thought that size and beauty of the fruit detracts from the flavor through an unbalanced expenditure of developmental energy.

IN analyzing and commenting upon the evidence rendered in a murder trial, the *Medico-Legal Journal* says that if every married woman who has a love affair with another man were to be punished by being in prison for ten years, what would be the percentage of married women out of state prisons? This is not very complimentary concerning the chastity of women in general, and we do not believe that it should be given such broad application.

THE Woman's Auxiliary to the American Medical Association will accomplish a great work if its members use their influence to sidetrack the efforts of a lot of club women who are proselyting for and encouraging quacks of various descriptions, and are secretly or openly favoring all sorts of propaganda and enterprises that ostensibly are in the interests of some phase of health work but which are diametrically opposed to all of the teachings of scientific medicine.

TOBACCO users will not be pleased with the announcement from the Kaiser Wilhelm Institute of Chemistry in Berlin that tobacco is a source of wood alcohol detectable in small amounts of tobacco smoke. It is estimated that about nine-tenths of the alcohol entering the body with the smoke is not exhaled but remains dissolved in the fluids of the body. In an excessive smoker, with an accumulation of this drug in the body, dangerous symptoms may be produced.

IT may not be amiss to call the attention of the members of the Association to the postal regulations which require that the names of delinquents be removed from our mailing list. Some of those physicians who are not receiving THE JOURNAL and are writing us snappy letters concerning the matter should take notice! We are put to considerable expense in revising our mailing list each year and the expense does not end until after dues have been paid and delinquency canceled.

THIS is a good time of the year to begin propaganda concerning a ban on fireworks. Firecrackers, toy pistols and other noise-making fireworks, placed in the hands of young Americans

who desire to celebrate the Fourth properly have been the cause of many cases of tetanus, lost fingers and eyes, and not infrequently death. If medical men will put forth the proper effort it is possible to arouse the public to the point where fireworks of every description will be prohibited.

The governor of New York has received a letter from a "nut" who claims to have discovered the primary cause of insanity, cancer, poliomyelitis, tuberculosis and, in fact, all diseases, and he offers his discovery for $150,000,000, to be paid in tax exempt, long maturity, United States liberty bonds! If the offer is not taken at once the price is subject to increase without notice. Up to the present time the governor of New York has not found the time nor the inclination to pay any attention to such a magnanimous offer.

In connection with the failure to convict Sinclair, and the actual whitewashing of all of the oil scandals involving millions of dollars and the reputations of many men, the remark has been made that "you can't convict a million dollars." Judging from some of our experiences in Indiana we are inclined to believe that you can't convict anyone on the charge of practicing medicine without a license, no matter what evidence is presented. Is it the fault of our laws, or is it a general contempt of our laws, and where are we drifting?

Four men have lost their lives as a direct result of investigations made by the public health service concerning the very fatal disease known as Rocky Mountain spotted fever. The most recent worker to lose his life from the disease is Dr. A. L. Kerlee, who occupied a position in the United States Public Health Service laboratory at Hamilton, Montana, as a bacteriologist. As the Bulletin of the United States Public Health Service says, "The warfare of science against disease has its hazards. Dr. Kerlee made the supreme sacrifice on the battlefield of the laboratory."

Why does so much quackery have its inception in Marshall, Michigan, and Davenport, Iowa? Of course, we are not unmindful of the fact that chiropractic flourishes in Davenport, but there are other species of quackery that advertise widely in the lay press and give Davenport as the home address. The old saying that "Birds of a feather flock together" probably holds true in connection with medical quackery. Thus Marshall, Michigan, a small and unimportant town, apparently harbors several medical fakes, though perhaps if the truth were known they all come from the same fountainhead.

Rabies is on the increase in Indiana. Doctor Rice's article in this number of The Journal is a graphic presentation of the subject. For the most part dogs are responsible for the spread of the infection, and usually it is a stray dog upon which no taxes are paid and no license fee has been exacted. The stray dog is not only worthless but a menace to the public as a carrier of rabies, and as a wild animal may inflict injury upon stock and mankind. The public must be impressed with the idea of the dangerousness of rabies and how it may be checked by the vaccination of dogs, and the treatment of humans who are infected.

"Modern conditions have made necessary business management in the physicians' offices. If the physician stands ready to give his services free to the needy poor, his business activities must be so managed that those who *cannot* pay will receive the benefit of his ministrations; and those who *can* pay will be charged in proportion to the seriousness of the illness, and the financial standing of the patients. Courts of law long have recognized that if the poor and needy are to have the doctor's services free of charge, the more fortunate of his clients must pay in proportion to their financial ability."—*Bulletin of Physicians' Fellowship Club,* Chicago.

Some physicians would avoid trouble and loss of professional reputation if they had sense enough to know their own limitations. They make a mistake in attempting to do that for which they are illy educated and inadequately trained. The old saying, "jack of all trades and master of none," holds true in the practice of medicine. No physician loses anything by admitting that there are some things he cannot do, or that some of the things for which patients consult him can be better treated and managed by those who have been specially educated and adequately trained for such work. Nowhere is this exemplified more than in cases requiring major surgery.

As we often have said, a secretary can either make or break any society. This being true, it is absolutely necessary for the county medical societies of Indiana to select their secretaries with great care. An energetic, resourceful, progressive and good-natured secretary means a live, progressive and contented medical society. For the benefit of all county medical society secretaries we desire to announce that The Journal stands ready to give them every possible assistance in putting their county medical societies on the map. Condensed reports of meetings, with short abstracts of papers and discussions, are solicited for publication. Also news notes and personals will be acceptable. Send in your copy.

The British Empire Leprosy Relief Association announces that a positive cure for leprosy has been found in hydnocarpus oil. For ten years scientists have been working to extract an oil from the dried fruit of the hydnocarpus tree and which can be used safely in the fight against leprosy. The virtues of this oil have long been known, but

its uses are restricted because it blocks the veins and chokes off the blood stream. As now perfected the hydnocarpus oil has one hundred percent efficiency in the early stages of leprosy and thirty percent in the advanced stages of the disease. It will be injected directly into the blood stream, and is thought to be far more efficient than chaulmoogra oil, which is injected into the muscles.

A DEATH following the removal of ten diseased teeth at one time is reported in northern Indiana. In that particular instance no physician was consulted concerning the advisability of carrying out so much general surgery at one time. The closest cooperation between the dental and medical professions would have a tendency to discourage such recklessness. Generally speaking, the removal of more than one or two septic teeth at one time is not advisable, as every effort should be put forth to prevent throwing too much septic material directly into the circulation. Furthermore, these cases should have the strictest medical and surgical care. In fact, all the precautions should be observed that are observed in any major operation.

THOSE physicians who are pipe smokers will be interested in a contribution to the *Scientific American* concerning "breaking in" a pipe. The simple method of converting a new pipe almost into an old one in one smoke is described as follows: Mix granulated sugar with water in the palm of the hand to the consistency of a rather thick paste. With the finger dipped in it, coat the inside of the bowl of the new pipe. Sprinkle tobacco into the bowl lightly. Light the pipe and smoke. The hot tobacco chars the sugar, combines with it, and forms a shell at once, apparently cutting off the irritating oils and vapors from the wood. This method makes the new pipe smoke almost like an old one, or at least much better than one started in the ordinary way.

A CORRESPONDENT in the *American Journal of Ophthalmology* for March says that he thinks that the term "eye surgeon" should be given to those physicians who have been trained to treat diseases of the eye, do surgery of the eye, and prescribe glasses. In other words, the term is to take the place of ophthalmologist, which is cumbersome and requires an explanation to the ordinary layman, to say nothing of being confused with optometrist, just as oculist is confused in the minds of the public with optician. He believes it is logical to speak of "eye surgeons," and that the term would give ophthalmologists a standing in the minds of the public as being engaged in surgical as well as medical work. The suggestion is worthy of serious consideration.

IF you haven't used salt pork to control nasal hemorrhage, Dr. L. M. Hurd, of New York (*Archives of Otolaryngology*, November, 1927), recommends that you try it. Larding pork kept in a saturated solution of sodium chloride is practically sterile. Several factors aid in producing the desired result, namely pressure, salt, tissue juices and fat. It is known that a ten percent salt solution shortens the clotting time of blood by one-half, and the effect lasts fifteen minutes. It is presumed that the pork holds the salt in contact with the bleeding surface and by osmosis continues to give up salt in small quantities for about one hour, or long enough to establish a firm clot. The pork, being greasy, usually slips out spontaneously and does not damage the well-formed clot.

THERE is nothing quite so pathetic as the actions of an old physician who in reality is out of the running and should be content to relinquish part of his work but who vainly tries to keep up with the procession in every way through bizarre and spectacular efforts to keep his name before the medical profession and the public. However, perhaps on the whole he is not to be censured or pitied any more than we censure or pity the younger man who does not know his limitations. There was a time when men retired from active work, but that day has passed and now the worker in almost any line of human endeavor continues in harness until the last, and oftentimes his mental vigor and judgment is better than that of younger men though physically he is incapable of carrying out the urge of ambition.

THE November-December number of the *Medico-Legal Journal* makes a good point when it condemns the value of smell in determining whether or not a person has consumed alcoholic liquor, for the test is of more value in the negative than in the positive. It is pointed out that while in a person arrested or found unconscious the presence of the odor of alcoholic liquor tends to prove that the individual has recently consumed alcohol, yet it must not be forgotten that the presence of the odor may have been produced purposely by other individuals either forcing alcoholics on an unconscious and unwilling subject, or by pouring same over the clothing of the person. This point is well taken and should be in the minds of the police department when dealing with cases in which alcohol may be an important factor.

THE daily papers carry the announcement that a three-year-old boy smokes cigars like a confirmed smoker, and must have his customary allowance or there is trouble in the family. As a mere side issue it is announced that the boy's health depends upon his tobacco smoking. We can well imagine that every kid in the country old enough to read will hear about the news and at once proceed to smoke, and with the claim to dear mother that it is necessary to health. We also can well imagine that the Anti-Tobacco League mem-

bers will throw seven kinds of fits when they realize what result the publishing of such sensational news will have upon Young America. However, the sensational news may be just a newspaper yarn, probably largely made out of whole cloth, and for the moment is a sensational piece of fiction.

Seasickness is a rather common malady and many remedies for its relief have been offered, though few have given relief. Now comes J. Frank Pearcy and Daniel B. Hayden (*Journal A. M. A.*, April 14, 1928), who selected sixteen persons suffering from seasickness, eight of whom were given three to five grains of sodium nitrite every two hours until they experienced relief. The average period of time before the members of this group were free from the various symptoms of seasickness, were comfortable on deck and able to eat meals, was four hours, and they did not suffer from any recurrence. The patients who did not have the nitrite treatment continued to suffer from seasickness. For anyone intending to take an ocean voyage it would be well to remember this treatment and try it out on themselves or their friends if seasickness occurs.

A notorious medical faker who imposes upon the ignorant and credulous by a species of legerdemain and tomfoolery, but who is reported to supplement her incantations by prescribing certain medicines, has been acquitted by a jury in an Allen county court of the charge that she was practicing medicine without a license. An ovation in her honor was staged by a bunch of ignorant and deluded followers. The whole proceeding is a fine commentary upon the consistency and judgment of the average lay person when it comes to deciding upon ignorance and superstition as against education, training and judgment. Furthermore, the precedent established, to say nothing of many other precedents that might be mentioned, indicates that our medical laws, even the one passed by the last legislature, might as well be wiped off the statute books.

Even the Internal Revenue Office has considered physicians "easy marks," or at least it looks that way in view of the fact that inconsistent and unfair discrimination against the physician has been employed by the income tax department as evidenced by the ruling of the commissioner of internal revenue denying the deductibility of traveling expenses incurred by physicians in attending medical meetings, and the allowance of such expenses in the case of professional men other than physicians and to men engaged in the trades and in business generally. The reason for this may be found in the fact that no complaint was made until recently, and in consequence the government has been collecting taxes unfairly from physicians for the entire income tax period. It is hoped that the bill now in Congress aimed to correct this imposition will pass and be signed by the president.

If the Copeland Bill (S 3592) is passed by Congress, and osteopaths are put on the same basis as doctors of medicine throughout the entire federal government service, we may expect a similar recognition throughout most of the state governments. That would mean that there is to be no recognition of training and competency in recognizing and treating disease conditions of the human body. Why have medical laws, and why have any restrictions? It is just as fair to let the village farmer or blacksmith practice medicine in any form as it is to let the osteopath, chiropractor, naturopath, or any other "path" experiment upon the sick and suffering. The whole proposition makes us smile, for it only goes to show how little attention we give to politics, and really politics is what seals our fate. Really, we have done so little to stem the tide of inconsistency and ignorance.

In a few sections of the state some of the physicians are hobnobbing with the chiropractors. The way it is worked is as follows: The chiropractor sends his surgical cases to the surgeon, and his bad medical cases to the internist, and in return has referred to him the patients that seem to need a little massage or for whom perhaps massage will not be harmful. A physician in the southern part of the state who has a keen appreciation of what it means to be honorable and to follow our code of ethics wants to know what we think of the practice mentioned and how the trouble can be corrected. To our notion it is up to the local county medical society, through its board of censors, to bring to account any member who has so far lost his respect for professional ethics that he will indulge in any of the practices mentioned, and promptly suspend or expel him from his society upon trustworthy proof of unprofessional conduct.

Now is the time to begin prophylactic treatment for hayfever. It is necessary to determine the pollen that is responsible for the symptoms. This is made possible by vaccination with pollen extracts that are furnished by most of the biological manufacturers. Having determined the pollen that is causing the patient's symptoms, the prophylactic treatment is begun and this consists of the injection of the pollen extract and increasing the dose until tolerance is established. In some patients this may require a larger dosage than that recommended by the biologic manufacturers. Furthermore, in order to maintain the tolerance it often is necessary to administer the pollen extract throughout the entire season. The greatest number of successes will come to the physician who studies his cases and watches the effect of the injections, remembering that tolerance is created in some more easily than others, and definite dosages cannot be applicable to all.

IT makes us smile to see the quacks and medical pretenders take advantage of the propaganda that is being spread throughout the state and even the nation concerning the question of health examinations, and in particular that phase of it which is known as "Baby Week." One medical faker boldly advertises that the children of today are the nation's leaders of tomorrow and consequently their health should be conserved. Therefore, parents should avail themselves of the offer on the part of physicians to examine children gratuitously during Health Week and, of course, adding to this statement the one conveying the information that nowhere can this examination be carried out so intelligently and trustworthily as in the office of the aforesaid medical pretender. It is just another species of personal advertising that undoubtedly pays, for probably everything is fish that comes to the nets of the pretender, and each and every "free health examination" is a prospective paying patient.

THE Madison County Medical Society has formed a physicians' credit association which has an alliance with the local merchants' credit association. The physicians are furnished with a printed slip, to be mailed to delinquents, reading as follows:

"So many families are providing themselves with luxuries they cannot afford, and have nothing laid by to pay for medical and hospital care in case of sickness or accident, that it has become necessary to form a Medical Credit Association. This will prevent physicians from increasing their burden of work and responsibility in caring for those who do not or will not pay their physicians. Those who do not wish their names listed as entitled to no further credit by any physician must arrange some settlement of their overdue accounts within thirty days of receipt of this notice."

It is expected that if these slips are sent to all delinquents it will be possible to eliminate a deadbeat list entirely.

FOR sixteen years Dr. Frederick C. Warnshuis has been secretary-editor for the Michigan State Medical Society. Recently the offices have been separated, and Dr. Warnshuis continues as secretary and general manager while the editorship of the *Journal of the Michigan State Medical Society* is assumed by Dr. J. H. Dempster, of Detroit, Michigan. Under Dr. Warnshuis' administration the society and its Journal have made wonderful progress, but with an increase of duties and the time and energy required for the work of his society, he found it impossible to do justice to each and all of the activities and therefore voluntarily resigned from the editorship of the Journal. The new editor, Dr. J. H. Dempster, is well qualified by education, experience and temperament to assume the editorial duties, with every indication that the *Journal* over which he presides not only will continue to rank high among medical periodicals but will continue in its steady march of progress. We offer our sincere best wishes.

IN urging physicians and midwives attending a birth to file a certificate with the health officer of the town, city or county in which the birth occurred, within thirty-six hours thereafter, the *Bulletin of the Indiana State Board of Health* calls attention to the importance of the matter by saying that the birth certificates may be needed at any time in life to prove right to inheritance of property, insurance, pension, military service, school, vote, marry, employment in industries, American citizenship, passports for foreign travel, exemption from military service, nationality in foreign country, protection in foreign country, to hold certain offices, be admitted to certain professions, collect government compensation, or collect a soldier's bonus. Death certificates are equally as important, as the registration of a death may aid in the settlement of life insurance claims, and in the settlement of estates, matters of inheritance, pensions, etc. It costs nothing to register a birth or a death but it may be of inestimable value to the family in future years.

A WRITER in the *Journal of the Missouri State Medical Association* says that a physician in the navy (lieutenant) three years service, if married, receives $336 monthly, with increase every three years and with each promotion. It is argued that this is better than $600 per month received by a civilian confrere whose expenses in every way are much greater. We might add that the comparison is not good because there is not so much variance in living expenses as claimed. We happen to know a few medical officers of the army and navy and they complain that it requires some close figuring to make both ends meet. They do not look forward to the accumulation of any very large nest egg for the future. What really keeps them in government service is the regularity and sureness of the pay, the satisfaction that comes from an official position and the opportunity afforded for traveling and social contacts which come with official life. In fact, it is the meager salary offered for medical service that detains so many young physicians from entering the army and navy.

THE *New York State Journal of Medicine*, the official organ of the medical society of the State of New York, has withdrawn from the Association of State Medical Journals sponsored by the A. M. A. and formed for the purpose of elevating the standard of medical advertising. We can believe that the principal reason for such a move is commercial, if the character of some of the advertising now carried by the *N. Y. State Journal of Medicine* is considered, and certainly it is not in keeping with the highest ideals of medical journalism. It is a pity that a periodical representing such a large and influential body of physicians as those

belonging to the New York State Medical Society should let the question of advertising income influence the managers to the point where they will accept medical advertising that practically all of the other state medical journals reject. Well, money is a powerful influence in swaying the opinions and even the consciences of some men, even though they be physicians supposedly advocating and following the highest standards of business and professional ethics.

A woman badly burned in a factory was treated for more than a year by a surgeon who during that time performed one or two skin grafting operations and gave other exacting attention. The woman compromised with the factory on a payment of twelve thousand dollars, and her attorney, who did not go into court but effected the settlement for her, presented her with a bill for two thousand dollars. The surgeon in the case, hearing of the attorney's charges, also put in a bill for two thousand dollars. The attorney promptly advised the physician that the bill would not be paid as it was excessive and that his client was a poor woman who needed all that she could get from her settlement with the company for whom she previously worked. "All right," said the surgeon, "you cut your fee in two and I will do likewise." To this the attorney objected, but as the surgeon was obdurate the attorney finally consented, which reminds us of the old saying that "It makes a difference as to whose ox is being gored."

Among current superstitions concerning medicine is the strange notion that in China the physicians are paid to keep people well and not paid when the people become sick. Apparently this belief is so well founded that Lord Cozens-Hardy in a recent discussion before the insurance companies of Great Britain urged the adoption of this system for that country. The idea, of course, is not a new one and the practice of preventive medicine is becoming more and more a part of the regular occupation of every physician in advanced countries. Some years ago, *The Journal of the American Medical Association* determined to find out once and for all what basis might exist for the belief that the Chinese regularly used the system referred to. An investigation made among educated Chinese, an inquiry to the Chinese embassy in Washington, D. C., and to the Chinese consulate in Chicago, revealed the unanimous belief that such a system has not existed in China recently and probably never did exist.—Morris Fishbein, M. D., *Scientific American,* February, 1928.

A layman who went to one of the famous clinics of this country returned after ten days of inside and outside exploration by numerous and diverse craftsmen, only to be assured by the head of the grist mill through which he had passed that there was nothing in particular the matter with him. In reporting his experience he said that he was "convict No. 634," duly tagged as such, and throughout his sojourn through the mill the attention, even though apparently thorough, was most impersonal in character. To use his exact words, "I got so fed up on the stereotyped and mechanical handling that I felt that if I said 'Good morning, Doc,' to the first manipulator seen at the beginning of the day's journey, I would pay the penalty by having a stomach tube rammed down my throat to keep me quiet. I came home with the same old pain in my inwards and my family doctor has cured me by telling me to cut out tobacco, go light on the food and take more exercise. He got five dollars for the advice and I paid the other fellows over three hundred dollars without getting even a smile for my pain. Me for the good old family doctor after this."

The Medical Protective Company has discontinued its fifteen dollar policy and now charges twenty-one dollars to secure what the company calls one hundred percent protection in malpractice suits. One of our members complains about this and asks what we are going to do about it? As a matter of fact the company in question has a right to determine its own policies without any suggestions or advice from us. From a purely personal standpoint we never have been able to understand the reason for increasing the rate for a protection policy such as furnished by the Medical Protective Company. If money is being lost on the fifteen dollar policy there may be some excuse for raising the premium, but judging from the amount of assets piled up by the company in question, and the dividends paid to stockholders, it would seem that nothing has been lost in furnishing the medical profession with a fifteen dollar policy. However, as we already have intimated, it is up to the physician to decide whether he will pay twenty-one dollars for protection or not. There is no question about the excellence of the services rendered, nor the financial standing of the company.

A physician needs to be very even-tempered to resist the temptation to punch the nose of the patient who after receiving surgical attention that accomplishes its purpose, waits until the bill is received and then puts up an unfounded complaint concerning bad results and perhaps even going so far as to claim that the condition is worse than it was before the operation. Some of these people are known to be "crabbers" in all matters that require the payment of money, and they do it for the distinct purpose of getting a reduction of charges. Others complain because they believe that a physician is an easy mark and that he will not press payment of an account if complaint has been made. One of the best ways to avoid a majority of such experiences is to tactfully insist upon payment at the time of operation or soon

afterward, and legal exactment of payment in those cases that promise to go to the deadbeat account unless such action is taken. No harm is done in exacting just payment from any patient, for if debtors are inclined to avoid the payment of an account they will be no worse enemies if compelled to pay than they are when they still owe an account that they have protested.

Concerning the credence given expert medical testimony in courts of law and the charge that medical men can be obtained who will give conflicting testimony, a correspondent says that there is no more difference of opinion among medical experts than among other experts, and that when all is said and done, it doesn't matter much what the testimony has been if the jury is not well-balanced, and a well-balanced jury is a rare thing to find. Oftentimes a jury is inconsistent and illogical in its reasoning, and it is swayed by emotion or sentiment rather than the facts brought out by witnesses. Furthermore, maudlin sentiment alone may be the sole reason for a particular verdict, but occasionally the verdict seems to be based upon a disrespect for law as evidenced by the verdict in some liquor cases and also in those cases which are based upon what is generally known as the unwritten law. However, we do believe that expert medical testimony would tend to be more uniform and less contradictory if compensation for the same is provided by the court rather than either the prosecution or defense. In other words, court-appointed experts should result in securing trustworthy testimony from medical men.

Many architects are prone to advise the addition of sun-parlors to residences with the idea in view of taking advantage of the benefits of the sun's rays in promoting health. No objection to this argument could be advanced if the architects provided for the use of direct sunlight without the interposition of glass. However, as the glass enclosed sun-porch or room is the one ordinarily provided by the architect, it seems necessary to disabuse the minds of the public concerning the value of the sun's rays unless they are direct, and even then the ultraviolet rays of the sunshine, which are the most important from a health standpoint, depend upon the duration of the exposure as well as atmospheric conditions, dust, smoke, etc. The season of the year, too, has some bearing on the case, as the sunshiny days of the early spring and summer show a greater increase of ultraviolet rays. Some effort has been put forth to manufacture glass that will transmit ultraviolet radiation, but with questionable success. Therefore, all things considered, it is well for the architects to know that sun-parlors, if designed with a view to getting the beneficial effects of the sun's rays, must not be enclosed in ordinary window glass but exposed to the direct rays.

A Chicago self-styled plastic surgeon, reported as an osteopath and by a questionable method licensed to practice in Illinois, is reported to have accepted an eight hundred dollar fee for removing a scar on the left arm and straightening some alleged bowing of the legs. No trustworthy evidence has been furnished to show that the legs needed straightening, but, at all events, an operation was performed, it was followed by gangrene and eventual loss of both legs, and the trouble nearly cost the life of the patient. While the patient's condition was critical the attending medical pretender announced that everything was going along smoothly. Finally the family insisted upon calling two reputable physicians, who removed the patient to a regular hospital and at once amputated the gangrenous legs as the only means of saving the patient's life. Investigation shows that the self-styled plastic surgeon has been guilty of quackish and illegal practices and in at least two instances was convicted and "served time." Just why Chicago tolerates such an impostor is hard to understand. A physician in good standing who apparently assisted the renegade has been expelled from the Chicago Medical Society and it serves him right.

While the general physician has been able to avoid night work by charging double for services rendered during the night hours, yet he still encounters many annoying incidents. One physician enjoying an enormous practice and needing his night rest was awakened about two a. m. by a telephone call from a woman who said, "Doctor, I just wanted to find out whether you would be in your office tomorrow forenoon or not." Another woman who probably suffered from insomnia, called about three a. m. and asked her physician if she had understood him the day before concerning medicine that was to be taken three times per day. Still another woman, whose curiosity got the better of her, called a physician by telephone at three a. m., and asked whether the child born next door a few hours previously was a boy or girl. In this connection we are reminded of a story that we heard years ago concerning a doctor who on a stormy night was called eight miles in the country to a supposed emergency case and upon reaching the house a woman's voice from an upstairs window said, "Doctor, is that you?", and upon being informed that it was she said, "Mary is so much better that we will not need a doctor. I don't suppose you'll charge for this visit, will you?"

This is election year and again we will hear the candidates talk about reducing taxes and "cleaning house." The voter will be wise if he pays no attention to such fairy stories. As a matter of fact our taxes have been increasing steadily for many years and the party that has howled the most about reducing taxes is the one that is responsible for most of the increase. When we talk of increase in taxes we mean money expended on

the part of the taxpayer, and not any rate that may be charged. In other words, the man who really has less property now than he had ten or twenty years ago is paying more money for taxes than ever before and it is the actual outlay in dollars and cents rather than the rate of taxation that must be taken into consideration. Furthermore, the taxpayer as a rule does not object to the payment of taxes if he gets an adequate return for the expenditure, but he does get peeved when he pays a constantly increasing amount of money for taxes and notes how recklessly and inconsistently his money is spent by those in office, and it doesn't make any difference whether the office holders are republicans or democrats. In reality what the taxpayers should do is to vote for men and not for parties, and even then they will be "stung" badly enough.

In the March 12th issue of *Time*, the Christian Science church was credited with having 635 churches with nearly 86,000 members in 1906, and at present an increase of churches to 1,912 and membership to 202,098. A reader of *Time* questioned these figures in a published letter which appeared under date of March 26th and is as follows:

> There is as much truth in these figures as there is in Mary Baker Patterson Eddy's statement in the year 1883 that "A million people acknowledge and attest the blessings of this mental system of treating diseases."
>
> According to the census of 1910 there were 85,717 Christian Scientists in the United States, but, as half of the members of the Boston (Mother) Church were counted also as members of their local churches the actual total was not more than 65,000. Likewise, the present alleged total should be revised down to about 140,000.
>
> That is to say, in a population of some 120 millions there is a little group of 140,000 who adhere to a brand of delusion known as Christian Science; and, in view of the fact that it is a delusion that fosters the withholding of anti-toxin from children choking with diphtheria, it is to say that even so few as 140,000 is too many.
>
> Burlington, Iowa. C. L. Dean.

The trouble with the average Christian Scientist is that his ideas of truth are considerably warped, and we positively know that some of the Christian Scientists are just plain hypocrites inasmuch as they do not practice what they preach.

The Minnesota State Medical Association has issued a pamphlet entitled "The Relation of the Medical Profession to the Public," which concisely and intelligently answers many of the questions put by the public concerning the work and accomplishment of the medical profession in caring for and improving individual and community health. In the preface it is announced that education of the public is the most important factor in many of the problems of health and that three groups should assume leadership: First, the medical profession, the members of which are by virtue of their training essential leaders; second, the engineers of sanitary science, upon whose shoulders rest the responsibility of such problems as water supply, sewerage disposal and drainage; third, a group such as teachers, nurses, technicians and lay workers, who under the advice and direction of physicians and public health officers should strive along the same humanitarian lines. Just as the practice of medicine is changing, so must the public be kept informed as to the actual facts and new truths of health discovered.

We believe that this little booklet might, with certain modifications, be used in every state in the Union. In it is incorporated most of the questions that have been raised by lay persons and each is answered in a comprehensive manner.

Not long ago we heard a prominent physician talk before a medical society concerning the necessity of a thorough and painstaking examination in order to arrive at the proper diagnosis and enable the physician to prescribe trustworthy treatment. His talk fell flat with us for we happened to know that he not only goes to an ordinary optician for his glasses, but is guilty of sending a patient with simple glaucoma to the same optician who prescribed glasses and in consequence there was a delay of several months before the patient finally awoke to the necessity of consulting an eye surgeon, and by that time considerable vision had been lost unnecessarily through delay in receiving appropriate treatment. If an eye surgeon went to a chiropractor to have an appendicitis treated it is certain that a howl would go up from the high-brows in the medical profession concerning the inconsistency of such a move, and yet it would be no worse than for a medical man to have his eyes examined by an optician or a jeweler. A proper examination for glasses includes ophthalmoscopic examination, and oftentimes serious pathology is discovered that is unknown to the patient and which appropriate treatment perhaps may eliminate. An ophthalmoscopic examination is worthless unless made by a medical man who has been trained to do that kind of work.

A Michigan physician now in his ninetieth year, and still practicing medicine, was tendered a banquet by some of his confreres. In responding to the welcome the old doctor gave some interesting reminiscences concerning the early years of his practice, and offered some suggestions and comments that we feel are worthy of reproduction for the benefit of the younger physicians, and we quote as follows: "It is true that I have been in the harness for a good many years, and it is my privilege to be old in years but young in spirit. There are thousands of men who grow old before their time. With idleness they become restless, discontented and unhappy. Such a life results in physical and mental decay. I have no elixir of life to offer. Keeping in touch with professional current events and abreast of the times, conjoined with correct habits of life, are important factors in delaying old age and alleviating the effects of senility. In my younger days, the more I worked

the more I wanted to work, and the more I worked the more I enjoyed my work. Work is a great safety valve. It keeps us out of mischief and promotes our happiness. * * * My advice to all young physicians is to give your undivided attention to your profession, free from all entangling outside ventures. When you become rich or wish to retire, take up anything which your mature judgment approves of as a fad or a sideline."

WE are receiving a lot of literature on the question of how to prevent war and note that many of our exchanges are discussing the question. We are quite in sympathy with the suggestion made by *Southern Medicine and Surgery* that one of the things that would help to prevent war would be a law that would permit no man, woman or child to own a cent's worth more at the close of a war than at its beginning. This would shut out the profiteering of manufacturers of munitions, as also the profit made by others who make war an excuse for extortion. To this we would add another requirement, that in case of war every able-bodied male above eighteen years of age should be drafted, and no matter whether assigned to civilian or war occupations the wages of all should be alike. This idea of paying boys in the trenches thirty dollars a month, and others, perhaps drafted or subject to the draft, a wage of from twenty to twenty-five dollars *per day*, as was the case during the last war, is the height of absurdity to say nothing of being criminal favoritism. When able-bodied young men of twenty-five to thirty years of age, working in the government shipyards during the war, struck for higher wages at a time when their services were needed in producing ships to take our boys to Europe, many of us thought that the proper way to settle such demands was with a firing squad. When you take individual profit out of a war we will have no war.

SENATOR ROBINSON, of Indiana, has introduced in the Senate an amendment to the Revenue Reduction Bill which, if passed, will authorize physicians to deduct traveling expenses in attending medical meetings when they compute their income taxes. Our Association has sent a letter to each of the Indiana Congressmen at Washington asking them to give favorable consideration to the bill. We desire to acquaint the Indiana physicians with the attitude of these congressmen, and accordingly report as follows:

Favorable to the amendment: Noble J. Johnson, fifth district; R. N. Elliott, sixth district; Ralph E. Updike, seventh district; Will R. Wood, tenth district; David Hogg, twelfth district.

Non-committal: H. E. Rowbottom, first district; Albert H. Vestal, eighth district; Fred S. Purnell, ninth district; Albert R. Hall, eleventh district; Andrew J. Hickey, thirteenth district.

No answer received: Arthur H. Greenwood, second district; Frank Gardner, third district; Harry C. Canfield, fourth district.

Senator Watson, as we already have noted in the April number of THE JOURNAL, is unreservedly in favor of the amendment, and we have reason to believe that as a member of the finance committee he is using much influence in behalf of the amendment. We urge the physicians of the state to bring influence to bear upon the Congressmen in their several districts in the hope that the representatives will follow the lead of Senators Watson and Robinson in favoring the amendment.

AT the present time several detail men are canvassing Indiana in the interests of pharmaceutical houses and offering samples and literature of proprietary preparations that have *not* been approved by the Council on Pharmacy and Chemistry of the A. M. A. One glib salesman selling a patented tonic has the effrontery to say that the physicians of Indiana do not care a tinker's dam about the council's findings and are quite willing to take a preparation upon the recommendation of the manufacturers and prove to their own satisfaction the value of the preparation. If we really thought that this salesman was telling the truth, and that the physicians of Indiana are such a lot of pale blue asses as to believe the average detail man who comes to them with fairy stories concerning pharmaceutical preparations that have not been passed and probably could not be passed by the Council on Pharmacy and Chemistry of the A. M. A., we would feel like deserting the profession and humbly declaring that we have no faith in either the intelligence or the honesty of medical men. It is quite possible that some of the glib salesmen who are introducing proprietary preparations are telling the truth, and that the statements made by the manufacturers also are trustworthy, but experience proves that the contrary often is the case. The Council on Pharmacy and Chemistry of the A. M. A. so often has proved that the manufacturers lie like horse thieves concerning their preparations, that it is a wise plan for the careful physician to take the Council's findings and insist that any preparation offered for trial shall first have received the endorsement of the Council.

THE *Red Book of Eye, Ear, Nose and Throat Specialists* is published by the Professional Press, Inc., of Chicago, and the same concern publishes the *Eye, Ear, Nose and Throat Monthly*. It may interest the physicians of Indiana to know what the Bureau of Investigation of the American Medical Association has to say regarding the concern, and accordingly we reproduce from the *Ohio State Medical Journal* for March, 1928, the information furnished in answer to an inquiry concerning the enterprise:

"The *Eye, Ear, Nose and Throat Monthly* has as its editor one Thomas A. Atkinson, M.D., a man of unsavory professional antecedents. This man has claimed in

his letterheads, in his advertising matter, on the information blank over his signature, and on the witness stand under oath, to be a licentiate of the Royal College of Physicians, London, England, 1892.

"We have documentary evidence from the Royal College of Physicians, and other sources in London, denying that Thomas George Atkinson is, or ever has been, a licentiate of the Royal College of Physicians.

"Atkinson for some time was editor of the *Medical Brief*, an alleged medical journal that for years blackguarded the American Medical Association and represented the proprietary interests.

"Atkinson has also operated the so-called Chicago School of Refraction, a spectacle-fitting affair that purported to give courses of instruction by mail and also by residence. When the Chattanooga Medicine Company, the manufacturers of 'Wine of Cardui,' brought suit against the American Medical Association on account of the expose of their nostrum, Atkinson was employed by the 'patent medicine' people as an expert.

"*The Red Book of Eye, Ear, Nose and Throat Specialists*, that is also published by the Professional Press, Inc., publishers of the *Eye, Ear, Nose and Throat Monthly*, is obviously a commercial affair. It is evident from the letters you send that any man who professes to be a specialist in eye, ear, nose and throat work and is willing to pay the price asked, can have what is, essentially, an advertisement of himself in this so-called *Red Book*."

WHILE the scientific program at the Gary session of the State Association, September 26-28, will be the main attraction of the meeting, yet the entertainment features have come to be of quite some importance. The local entertainment committee announces some unusual features for the coming session. Golf, of course, will occupy the attention of the sportively inclined members. The Gary Country Club, conveniently located to the city, has tendered the use of its grounds and clubhouse for the day. Wednesday afternoon the men will be taken through the Gary works of the Illinois Steel Company. This trip, some three or four hours in length, is made via an observation train. Frequent opportunities will be afforded to leave the cars and make a close-up inspection of certain departments. This is said to be the largest and most modern steel plant in the world. Wednesday night is the annual smoker, a complimentary party tendered by the Lake County Medical Society. This will be held in the ballroom of the Gary Hotel. The committee is planning a very elaborate entertainment, and promises an evening of wholesome fun, with plenty of refreshments. Thursday night is set apart for the annual banquet, which also will be held in the Gary Hotel. Dancing will conclude the evening. For the ladies will be offered a diversified list of parties, trips, etc. On Wednesday afternoon there will be a motor trip through the Calumet region, known as the Workshop of the World. The same evening a special theatre party has been planned. Thursday morning there will be a motor trip through the Dunes, the new state park. At noon a luncheon at the park pavilion, with cards in the afternoon. The ladies, of course, will attend the banquet on Thursday evening.

IN the April number of THE JOURNAL we commented editorially upon the dangers of some of the welfare agencies as they pertain to medical and surgical service, and we have been asked why we did not make more distinction and give some credit to *organized* social work as compared to the unorganized haphazard and even commercial welfare work done by certain individuals and societies. As one social service worker says, "Organized social service, conducted along rational lines, is a valuable economic factor in any community where it is carried out, and works no harm to principle or organization. However, organized social service is more hampered by a lot of fool women and a few spineless men who engage in welfare work without rhyme nor reason, and whose actions are swayed by maudlin sentiment or irrational ideas of value to the community. If medical men and all others will permit organized social service workers to manage the problem of distributing charity of whatsoever kind, there will be little cause for the just criticism which you and others offer concerning the irrational and oftentimes superfluous service rendered by welfare charitable organizations that are dominated and controlled by individuals or societies having no rational or systematic methods of carrying on." To all of which we say, "Amen," but our word of warning has particular reference to the question of commercializing medical charity, though we did comment on the inconsistency of furnishing medical charity to the undeserving and thus helping to create dependency on the part of some people who, if not helped so much, would be more self-supporting and a greater asset to the community. We believe in organized charity, and we know that the average physician is as charitable as those following any other vocation, but we are opposed to the kind of charity that is put into effect by many so-called charitable or welfare organizations that carry on without judgment or reason.

THE city of Portland, Oregon, has come in for some rather unfavorable notoriety in connection with the so-called Kirkpatrick Cure for Tuberculosis which a few months ago received eulogistic endorsement on the part of the mayor and other substantial citizens of Portland. An investigation of the subject on the part of the reputable medical profession of Portland shows that the whole enterprise was a species of quackery and that a few physicians, presumably in good standing, were interested in it because of the commercial gain derived. A committee authorized by the city council of Portland, and appointed by the very mayor who had endorsed the Kirkpatrick treatment, made a thorough investigation and has just filed a report declaring unanimously that the Kirkpatrick nostrum is without value in the treatment of tuberculosis and its use as such constitutes a menace. In commenting upon this the *Journal of the A. M. A.* of March 31st says,

"Certain facts brought out during the committee's investigation are of more than academic interest to the organized medical profession not only of Oregon but of the country. When Mayor Baker testified before the committee he declared, in effect, that his enthusiasm for the Kirkpatrick treatment was based on the eulogistic reports he had received regarding the nostrum from Drs. Ralph C. Walker and Carl T. Ross, each of them members of the Oregon State Medical Society. The committee brought out further that Dr. Walker was a stockholder in the Kirkpatrick Remedy Company, and that both Dr. Walker and Dr. Ross had profited through their tie-up with the Kirkpatrick outfit; that Dr. Walker is a roentgenologist and made roentgenograms of victims sent to him by Grant Smith, the hired "M. D." of the Kirkpatrick concern, and a one-time advertising venereal quack. Dr. Ross made physical examinations of the same victims. However, the Kirkpatrick consumption cure fake will live for a considerable time, even though it has been condemned by a trustworthy committee appointed to investigate its merits. It is reported that the Abrams electronic quacks are adopting the Kirkpatrick treatment, with the statement that it fits in nicely with their method of treatment."

THE spring crop of baby clinics are nothing short of live-stock shows for fond mothers who desire to have their children rated as to points, not for health's sake but largely out of curiosity or neighborhood rivalry, as also the incentive of getting something for nothing. The trouble with these baby health shows is that they accomplish little or nothing, for to be valuable they must reach the class for whom they are intended, namely the indigent. Most of the physicians who have been the dupes of women's clubs and welfare organizations of one kind or another have learned that they donated their services to a cause that accomplishes little good, and they are refusing to cooperate further in the promulgation of an enterprise that has so little to commend it. No doubt the lay sponsors for the movement are sincere in their efforts, but the whole trouble is that the enterprise is not well managed and is not carried on with the idea of making it worth while to a class of people that deserve help. For instance, when you find mothers belonging to the better class, and who admit employing some of the finest physicians in the community, taking their youngsters to a free clinic just because they can get something for nothing and want to find out what will be said about their darling offspring, it can be seen that the enterprise falls short of accomplishing the purpose for which it is established. The promoters are not only optimistic concerning the benefits secured from such enterprises, but we are sorry to say that they sometimes color their reports to the point of gross exaggeration.

The remedy lies in having these health clinics conducted under the sponsorship of organized charity, and the policies dictated by the medical profession upon whom the greatest responsibility rests. Without medical men the health clinics would fail, but as conducted at the present time the health clinics are largely if not wholly dominated and controlled by lay interests, with the medical profession as "the goat." Medical men should be something more than the spineless dupes of lay organizations that start a lot of activities without rhyme or reason, and in the matter of rendering efficient and intelligent services to the sick and afflicted among the indigent and poor the medical profession should have a voice in how, when and where such service is to be rendered. There is altogether too great a tendency on the part of medical men to let someone else boss them.

DEATHS

CARL G. WINTER, M.D., of Indianapolis, died March 26th, aged 54 years. Dr. Winters was graduated from the Eclectic Medical College, Cincinnati, in 1893.

CHRISTOPHER H. WOLFE, M.D., of Clay City, died March 26th, aged seventy-six years. Dr. Wolfe had retired from the active practice of medicine. He was graduated from the Louisville Medical College in 1876.

ALBERT I. GILBERT, M.D., of Kewanna, died March 21st, aged fifty-five years. He was a member of the Fulton County Medical Society, the Indiana State Medical Association and the American Medical Association.

O. M. STOUT, M.D., who practiced medicine near Bloomington for many years, died following a long illness in a hospital in Indianapolis March 29th. Dr. Stout was sixty-four years of age. He was a graduate of the Curtis Physio-Medical Institute of Marion in 1891.

W. W. TUCKER, M.D., of Greencastle, died March 16th, aged sixty-one years. Dr. Tucker was graduated from the Miami Medical College, Cincinnati, in 1889. He was a member of the Putnam County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

DAVID E. JOHNSTON, M.D., of Moores Hill, died March 21st, aged fifty-five years. Dr. Johnston was a member of the Dearborn County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He was graduated from the Medical College of Indiana, Indianapolis, in 1900.

BENJAMIN F. BEAVERS, M.D., of Decatur, died April 2, aged thirty-seven years. He graduated from the University of Kansas School of Medicine, Lawrence and Kansas City, in 1921. Dr. Beavers

was a member of the Adams County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

Elijah E. Mitchell, M.D., of Bedford, died April 10th, aged sixty-three years. Dr. Mitchell died from injuries sustained in a fall. He was graduated from the Kentucky School of Medicine, Louisville, in 1888. He was a member of the Lawrence County Medical Society, the Indiana State Medical Association and the American Medical Association.

John W. Lisman, M.D., of New Lebanon, died April 5th, aged seventy-four years. Dr. Lisman had retired from the active practice of medicine. He was a member of the Sullivan County Medical Society, the Indiana State Medical Association and the American Medical Association. He was graduated from the Medical College of Ohio, Cincinnati, in 1878.

Samuel Dodds, M.D., of Logansport, died March 28th, aged sixty-one years. Dr. Dodds was superintendent of the Northern Indiana Hospital for the Insane. He was a graduate of Jefferson Medical College, Philadelphia, in 1889. He was a member of the Cass County Medical Society, the Indiana State Medical Association, the American Psychiatric Association and a Fellow of the American Medical Association.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in The Journal of The Indiana State Medical Association. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

Dr. John H. Musser, of New Orleans, has been named president-elect of the American College of Physicians, to serve in 1929.

Dr. Chas. F. Neu, Indianapolis, addressed the Madison County Medical Society at its regular monthly meeting at Anderson, March 20, upon "Epidemic Encephalitis."

Dr. A. J. Sparks has announced the opening of offices in the Wayne Pharmacal Building, Fort Wayne. His practice is limited to diseases and surgery of the genito-urinary organs.

Dr. W. W. Beauchamp, of Lima, Ohio, was selected as president of the Northern Tri-State Medical Association at the closing session of the fifty-fifth annual convention at Detroit.

B. R. Kirklin, M.D., formerly of Muncie, but now with the Mayo Clinic, presented a paper on "Cancer of the Lung" before the meeting of the Indianapolis Medical Society on April 3rd.

Mr. George F. Harvey, one of the prominent manufacturers of pharmaceutical and biological products in this country, died April 26th, aged eighty-five years, at his Edge Hill residence.

More than twenty million cattle are now under supervision as the result of tuberculosis eradication work. During February more than 740,000 cattle were tested, and about 18,000 were condemned.

The Howard County Medical Society held a meeting April 6, at Kokomo. Thirty-five doctors attended the meeting. Dr. Clifford G. Grules, of Chicago, presented a paper on "Bone Diseases of Infancy."

The Carroll County Medical Society held its first meeting for 1928 at the home of Dr. W. O. Hildebrand, of Topeka, April 11. Dr. E. H. Funkhouser, of Indianapolis, presented a paper on "Intestinal Stasis."

Dr. A. P. Roope, of Columbus, recently had his right hand amputated above the wrist, the procedure becoming necessary as the result of mercurial poisoning, contracted when a mirror broke and cut his hand.

W. B. Saunders Company, of Philadelphia, has just issued a new, eighty-page, illustrated catalog of medical books, containing more than 250 titles. A copy of the catalog will be sent to any physician upon request.

Dr. James H. Stygall, of Indianapolis, presented an all-day clinic at the Kehrer Tuberculosis Hospital (near Anderson), April 18th. This clinic supplanted the regular April meeting of the Madison County Medical Society.

The Vigo County Medical Society held a dinner meeting at St. Anthony's Hospital, Terre Haute, April 10th, in honor of Dr. T. W. Moorhead, who celebrated his fiftieth anniversary as a member of the society on April 9th.

C. J. Broeman, M.D., of Cincinnati, addressed a meeting of the Dearborn-Ohio County Medical Society, March 29th, at Aurora. His address was "Indications for Radium in Cancer and Skin Diseases," which was illustrated with lantern slides.

Dr. T. W. Moorhead was honored at the April meeting of the Vigo County Medical Society, celebrating the fifth year of his membership in that society. Dr. Moorhead joined the society in April, 1878. A scientific program followed the dinner.

At the regular meeting of the Muncie Academy of Medicine, held Friday, April 13th, at the Hotel Delaware, Dr. P. M. Hickey, of the University of Michigan, presented a paper on "The

X-Ray in the Diagnosis of Bone Diseases of Childhood."

THE American Hospital Association held a two-day session in Indianapolis, April 10th and 11th. Speakers included James A. McNamara, Chicago; Dr. M. T. McEachern, of Chicago; and Dr. Irving S. Cutter, dean of Northwestern University Medical School.

THE Northeastern Indiana Academy of Medicine held a meeting at the new Lakeside Hospital, April 26th. Following the dinner, Dr. Charles P. Emerson, dean of the Indiana University School of Medicine, presented a paper on "Functional Psycho-neuroses."

DR. CHARLES DANCER, Fort Wayne, was the principal speaker at the regular monthly meeting of the Noble County Medical Society, which was held at Albion, April 17. "The Endocrines with Special Reference to the Thyroid" was the title of Dr. Dancer's paper.

DUE to the death of two of its oldest doctors, Dr. W. A. Listman and Dr. G. W. Pirtle, the town of Carlisle, Indiana, is in need of a physician. Any interested physician may write to THE JOURNAL or to James J. Pirtle, 511 North Fess Street, Bloomington, Indiana.

THE Eleventh Councilor District Association will hold its next meeting at Peru, May 17, 1928. Dr. William Jenkins, of Louisville, and Dr. Herman S. Kretschner, of Chicago, will present papers. President Dr. J. H. Reed, of Logansport, will present his inaugural address and Dr. Chas. H. Good, of Huntington, will report a case of actinomycosis.

THE American Association for the Study of Goiter, consisting of internists, pathologists, radiologists, etc., as well as surgeons, will hold its fifth annual conference on goiter, in Denver, Colorado, June 18th, 19th and 20th. Several men from foreign countries have signified intentions of attending. Professor Breitner, of the Von Eiselberg Clinic, Vienna, and Professor Albert Kocher, of Berne, Switzerland, have accepted places on the program. All members of the State Medical Societies are invited to attend. Dr. Gordon S. Fahrni, of Winnipeg, Canada, is the president, and Dr. Kerwin Kinard, of Kansas City, is vice-president of this association.

AN unusually interesting meeting was held by the Indianapolis Medical Society recently when Walter Shead, a newspaper reporter of the Indianapolis *News* told the inside story of his expose of the Briggs' Diploma Mill, an institution which was issuing chiropractic and naturopathic licenses in Indianapolis. Dr. E. M. Shanklin, of Hammond, Indiana, secretary of the State Board of Medical Registration and Examination, also spoke upon the problems and need of the State Medical Board. Dr. Howard Lilienthal, chief consulting surgeon, Mount Sinai Hospital, New York City, addressed the Indianapolis Medical Society March 27 upon "Surgery of the Chest." Dr. B. R. Kirklin, Mayo clinic, spoke upon "Pulmonary Malignancy" before the Indianapolis Medical Society April 3. The discussants were Dr. James H. Stygall and Dr. William F. Molt.

ANNOUNCEMENT has been made that the Maltbie Chemical Company, of Newark, New Jersey, has contributed a grant for a research fellowship for the coming year to the Department of Chemistry of Princeton University. The research work to be done under this fellowship will be fundamental in character and will cover certain phases of the chemistry of creosote and creosote compounds.

AT a recent meeting for the alumni of the St. Louis City Hospital, the Medical Society of the St. Louis City Hospital was reorganized and any externes are reinstated in good standing on payment of this year's dues. A meeting is planned for June, 1928, the exact date of which will be announced later. A roster of living members from 1875 to 1928 is now being arranged. All members in outlying states are requested to communicate with Dr. William T. Coughlin, president, or Dr. J. J. Burdick, of 2106 East Grand Boulevard, St. Louis, Missouri.

FORTY-TWO members out of seventy-four who were graduated in the class of 1903 from the Indiana University School of Medicine attended the twenty-fifth reunion of the class in Indianapolis on April 18. Following luncheon at the James Whitcomb Riley Hospital for Children, the physicians held an informal meeting at the Indiana University School of Medicine, the greater part of which was spent in reminiscencing and recounting events in their practice since graduation. The reunion closed with a formal dinner at the Elks' Club in the evening. Five years ago it was decided that the reunion should be held each five years so long as there were any survivors. Dr. C. E. Ferguson, now retired, who was professor of obstetrics during the college days of the class, was guest of honor. Dr. Charles N. Combs, Terre Haute, permanent secretary of the class, is the only officer.

OMICRON Alpha Zeta Chapter of Phi Beta Pi was host to an assembly of chapters from the north-central states March 9th and 10th. A banquet was held March 9th at the Lincoln Hotel, Indianapolis, when forty-eight alumni from over the state were present. On March 10th the guests were taken through the Indiana University School of Medicine and Hospitals and in the evening a dance was given at the Spink-Arms Hotel. The

following were initiated at the annual initiation of pledges: Byron J. Smith, Yeddo; Clarence W. Brown, LaPorte; William W. Nichol, Oakland City; Leslie A. Laird, Mentone; A. F. Melloh, Indianapolis; Edward S. Post, South Bend; J. D. Rogers, Gosport; S. J. Ferraro, Gary; Charles H. Denzler, Jeffersonville; A. J. Steffen, Huntington; Matthew Cornacchione, Indianapolis; C. J. Lewis, Ulysses, Pennsylvania; Carl J. Rudolph, Cleveland, Ohio; J. E. Gillespie, Wabash; Comiel Malstaff, Walkerton; Gayle J. Hunt, Richmond; V. J. Noone, Indianapolis, and O. C. Adkins, M.D., Indianapolis.

A new plan for monthly clinics has been established by the staffs of St. Mary's Hospital and Deaconess Hospital at Evansville. The program for the clinic at St. Mary's Hospital which was held the morning of April 3 follows: Dr. W. R. Hurst, Surgical Clinic (General); Dr. W. S. Ehrich, Urological Surgery Clinic; Dr. E. B. Long, Surgical Clinic (General); Dr. B. D. Ravdin, Surgical Clinic (E. E. N. T.); Dr. E. F. Magenheimer, Surgical Clinic (General); Dr. Harmon Stanton, Surgical Clinic (E. E. N. T).; Dr. Thomas Reitz, Medical Clinic, Auricular Fibrillation; Dr. Herman Baker, Medical Clinic, Pituitary Tumor with the End Results after Operation. The program for the clinics at the Deaconess Hospital the evening of April 26 follows: Dr. Robert R. Acre, Renal Lithiosis, Presentation of a case; Dr. H. G. Weiss, Diagnosis of Perforating Gastric Ulcer, presentation of a case; Dr. H. C. Ruddick, Axillary Adenitis Complicating Hand Infections, presentation of cases; Dr. P. B. Combs, Erythrymia or Osler's Disease, presentation of a case; Dr. O. C. Stephens, Diagnosis of Traumatic and Pathological Fracture of Ramus of Pubic Bone and Its Relation to Workmen's nosis and Treatment of, and presentation of a case.

Announcement is made of the opening on March 31, 1928, of the newly and completely equipped Chevalier Jackson Bronchoscopic Clinic of the new Graduate Hospital of the University of Pennsylvania at Nineteenth and Lombard Streets, Philadelphia. The new bronchoscopic clinic will be in personal charge of Dr. Chevalier Jackson, professor of bronchoscopy and esophagoscopy in the Graduate School of Medicine of the University of Pennsylvania. The clinic is very handsomely and completely equipped, through the generosity of Mr. Frederick S. Bigelow, a member of the Board of Hospital Managers. The Bronchoscopic Clinic of the Graduate Hospital will be the headquarters for bronchoscopic instruction to physicians who come to the Graduate School of Medicine for the regular courses in otolaryngology, or for the special courses in bronchoscopy. The special courses in bronchoscopy which are offered to otolaryngologists and surgeons are conducted at stated two weeks' periods to limited groups of physicians who have previously registered with the dean. The future periods thus far announced are as follows: May 28 to June 9, 1928, and August 6 to August 18, 1928. Further dates may be obtained from time to time by application to the dean, Dr. Geo. H. Moeker.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Adohr Creamery Co.:

B. Acidophilus Milk-Adohr.

Parke, Davis & Co.:

Solution Ephedrine Sulphate-P. D. & Co., 3 percent.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

March 26, 1928.

Meeting called to order at 4:00 p. m.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held March 19 read, corrected and approved.

The release, "Practical Psychoanalysis and Health," read and approved upon condition that it be reviewed by members of the committee not present.

The report of the representatives of the Indiana State Medical Association who attended the Indiana Tuberculosis Association at Gary, February 15 and 16, read. commended and approved. The Bureau suggested that this report be sent to the editor of The Journal of the Indiana State Medical Association for publication.

The following reports on medical meetings were made:

March 13, Knox County Medical Society. Report to be made.

March 13, Rush County, Center Township, Parent-Teachers Association. "Preventive Medicine Among Children." Report received and approved.

March 13, Madison Rotary Club. "Cardio-vascular Disease in Relation to Modern Business Life."

March 22, Crawfordsville. "Periodic Health Examination." Talk before the Rotary Club. Report not yet received.

Meetings to be held:

March 29, Cass County Medical Society, Logansport. Subject, "Plaster of Paris and Some Factors on Fractures."

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole April 2, 1928.

William N. Wishard, M.D.,
Chairman.

Thos. A. Hendricks,
Secretary.

BUREAU OF PUBLICITY

April 5, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting of March 26th were read, corrected, and approved.

The release, "Spring Cleaning," read and approved for publication Saturday, April 14.

The following bills were approved for payment:

Central Press Clipping Service	$ 5.00
The Bailey Office Supply	15.00
A. B. Dick Company	4.00
W. K. Stewart Co.	.60
Western Union Telegraph Co.	.63
	$25.23

The following reports on medical meetings were received:

March 5, Rush County Medical Society; "Early Diagnosis of Tuberculosis Campaign."

March 29, Cass County Medical Society, Logansport; subject, "Plaster of Paris and Some Factors on Fractures."

Letter was received from editor of THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION in regard to items appearing under the Indiana heading of the *Journal of the American Medical Association*. The secretary was instructed that copies of articles sent by the Bureau of Publicity to the American Medical Association to be printed under the Indiana heading in the *A. M. A. Journal* should continue to be sent to the editor of the JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION.

The Bureau of Publicity reviewed articles appearing under the Indiana heading in the *Journal of the American Medical Association* of March 31. Comment was made that Indiana is receiving better space in the *Journal* since the Bureau of Publicity has from time to time supplied notices for the *Journal*.

The secretary was instructed to send letters to the physicians of the Knox County Medical Society inviting them to attend the meeting to be held April 10th at Vincennes. The subject to be presented at this meeting is "Genito-Pelvic Infections and Their Treatment."

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole April 16, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

SECRETARIES' CONFERENCE

The first annual spring round-table get-together of the county medical society secretaries at Indianapolis, April 26, proved to be one of the most interesting and important meetings of the entire year.

A wide range of subjects, running all the way from the perplexing problems of dues collections and getting the members out for meetings, to such complex questions as the formation of multiple county medical societies and auxiliary activities, were discussed. It is safe to say that not a single one of the thirty-five or more secretaries who attended the meeting went away without getting something worth while out of the meeting.

J. C. Burkle, M.D., chairman of the Secretaries' Conference Committee, opened the meeting at seven o'clock immediately after the last course of the festive banquet was served and the cigars had been passed around, and when time was called at the end of the final round at ten o'clock, all contestants were still going strong. There was action all the way.

Besides the secretaries who attended, the following officers of the state society were present: C. E. Gillespie, M.D., president-elect; Albert E. Bulson, Jr., M.D., editor of THE JOURNAL; Wm. A. Doeppers, M.D., treasurer of the State Association and former secretary of the Indianapolis Medical Society, and E. E. Padgett, M.D., councilor for the Seventh District. Short talks were made by each of these men.

Subjects and the discussion leaders follow:

County Society Programs (material type of programs, etc.)—J. C. Burkle, M.D., Tippecanoe County, and R. G. Moore, M.D., Knox County.

Membership Problems (collection of dues, solicitation of members, best way of getting word to members, etc.)—T. R. Owens, M.D., Delaware-Blackford, and A. M. Mitchell, M.D., Vigo Counties, discussants.

Meetings (relative value of dinner meetings, joint meetings and meetings with other professional groups, such as dentists, lawyers, etc.)—W. T. Lawson, Danville.

Economics (fees for industrial cases, medical witness fees, expert testimony, etc.)—P. H. Schoen, M.D., Floyd County.

Social Activities in County Societies (functions, dinners, mixed meetings, Women's Auxiliary)—C. A. Stayton, M.D., Indianapolis Medical Society, and M. B. Catlett, M. D., Fort Wayne.

Among those who took part in the discussion of the program were the following: V. L. Turley, M.D., Fowler; J. K. Hawes, M.D., Columbus; J. L. Allen, M.D., Greenfield; E. R. Clarke, M.D., Kokomo; G. A. Collett, M.D., Crawfordsville; D. L. McAuliffe, M.D., North Vernon; P. H. Schoen, M.D., New Albany; M. A. Austin, M. D., Anderson; O. G. Brubaker, M.D., North Manchester; S. T. Miller, M.D., Elkhart; Ivan Carlyle, M.D., Sedalia.

The roll call showed the following present:

Joseph L. Allen, Greenfield, Hancock County.
M. A. Austin, Anderson, Madison County.
J. C. Burkle, Lafayette, Tippecanoe County.
C. E. Boyd, West Baden, Orange County.
O. G. Brubaker, North Manchester, Wabash County.
E. R. Clarke, Kokomo, Howard County.
I. E. Carlyle, Sedalia, Clinton County.
M. B. Catlett, Fort Wayne, Allen County.
D. S. Conner, Cannelton, Perry County.
Wm. A. Doeppers, Indianapolis, Marion County.
C. E. Gillespie, Seymour, Jackson County.
Max Gitlin, Bluffton, Wells County.
H. E. Grishaw, Tipton, Tipton County.
J. K. Hawes, Columbus, Bartholomew County.
G. E. Iterman, Newcastle, Henry County.
W. T. Lawson, Danville.
D. L. McAuliffe, North Vernon, Jennings County.
M. A. McDonald, Peru (substitute for secretary, E. H. Andrews, of Peru), Miami County.
R. G. Moore, Vincennes, Knox County.
A. M. Mitchell, Terre Haute, Vigo County.
E. R. Mason, Bloomfield, Greene County.
S. T. Miller, Elkhart, Elkhart County.
H. C. O'Dell, Sullivan, Sullivan County.
T. R. Owens, Muncie, Delaware-Blackford County.
E. E. Padgett, Indianapolis (Councilor, Seventh Dis.).
Allen Pierson, Spencer, Owen County
A. L. Spinning, Covington, Fountain-Warren.
P. H. Schoen, New Albany, Floyd County.
C. A. Stayton, Indianapolis, Marion County.
A. E. Steinson, Athens, Fulton County.
R. W. Shanks, Noblesville, Hamilton County.
V. L. Turley, Fowler, Benton County.
O. A. Turner, Madison, Jefferson County.

From time to time the papers and the discussion presented at the meeting will appear in THE JOURNAL. The special attention of all county society secretaries who were not able to be present at the meeting is called to these articles as they contain some ideas which may prove of practical value in any county society.

WOMAN'S AUXILIARY

April 30, 1928.

The first executive board meeting of the Woman's Auxiliary to the Indiana State Medical Association will be held Thursday, May third, at the home of Mrs. F. W. Cregor, Indianapolis. Attending will be the state officers: Mrs. W. R. Davidson, Evansville, president-elect; Mrs. A. C. Clauser, Delphi, recording secretary; Mrs. O. T. Scamahorn, treasurer; Mrs. I. N. Trent, councilor eighth district; Mrs. David Ross, president Marion County Auxiliary; Mrs. O. O. Alexander, presi-

dent Vigo County Auxiliary; Mrs. M. A. Austin, president Madison County Auxiliary; Mrs. William Moore, president, and Mrs. Orville Spurgeon, secretary-treasurer of the Delaware County Auxiliary; representatives from several districts; Mrs. John H. Hare, Evansville, First District; Mrs. W. A. Hall, New Albany, Third District; Mrs. Samuel Kennedy, Shelbyville, Sixth District; Mrs. W. S. Tomlin, Indianapolis, Seventh District; Mrs. Ora Lee McKay, Romney, Ninth District.

Mrs. Cregor hopes that all ladies who accompany their husbands to the American Medical Association convention in Minneapolis will be sure to attend one or more of the meetings of the Woman's Auxiliary to the A. M. A. She wishes them to listen carefully in order to get a national view of the Auxiliary; to carry home their messages to help further the work in Indiana.

NEW AUXILIARIES

Mrs. I. N. Trent, councilor of the Eighth District, announces the formation of an auxiliary to the Delaware County Medical Society. President, Mrs. William Moore; vice-president, Mrs. Arthur Kemper; secretary-treasurer, Mrs. Orville Spurgeon.

In the newly formed Auxiliary to the Carrol County Medical Society, Mrs. A. C. Clauser is president, and Mrs. Charles Crampton is secretary-treasurer.

The May meeting of the Woman's Auxiliary to the Vigo County Medical Association will be an indoor picnic for members and husbands at the Edgewood Grove Cabin.

The May meeting of the Woman's Auxiliary to the Indianapolis Medical Society will be held Friday, May fourth, at the home of Mrs. M. E. Harold. Assisting hostesses: Mrs. S. J. Copeland; Mrs. A. M. Hetherington, Mrs. William A. McBride, Mrs. William F. Molt. Program: A round table discussion, "Has the Home Lost Its Halo?" Leader, Mrs. Fred Pettijohn; songs, Miss Marjorie Harold.

Respectfully submitted,
MRS. F. W. CREGOR,
President, Indianapolis.

VANDERBURGH COUNTY MEDICAL SOCIETY

March 31, 1928.

The March meeting of the Vanderburgh County Medical Society was held at the Hotel McCurdy, Evansville, Tuesday evening, March 13. A banquet was given, which was followed by an address by Dr. Granville S. Hanes, of Louisville, Kentucky, on "Injections of Hydrochloric Acid as a Method of Treating Pruritis Ani and Vulva, Rectal Prolapse, and Other Infections of the Terminal Bowel." The talk was illustrated by lantern slides. Dr. Hanes gave not only an interesting but a very instructive lecture. A number of physicians from the adjoining counties were in attendance.

The city of Evansville is having considerable difficulty in checking an epidemic of smallpox. The question of compulsory vaccination of school children was seriously debated, but it was decided that an educational program, by means of letters addressed to the parents of the school children, be used instead. In addition to this, a public meeting is to be held at the Coliseum at which time a number of outside medical speakers will address the audience on the advantages of vaccination.

KEITH T. MEYER, M.D.,
Secretary.

April 14, 1928.

The April meeting of the Vanderburgh County Medical Society was held at the Welborn Hospital Clinic, Evansville, at 8 p. m., April 10th.

The following program was presented by the staff of that institution:

Clinical presentation of an infant with a congenital malformation of the anus—Dr. J. F. Wynn.

Practical demonstration of the multiple stethoscope—Dr. S. W. Wishart.

Symposium—Peptic Ulcer:

Moving pictures of various types of gastric ulcer—Dr. K. T. Meyer.

Medical treatment of peptic ulcer—Dr. C. L. Seitz.

Surgical treatment of peptic ulcer—Dr. W. R. Davidson

A large number of physicians from adjoining counties were in attendance.

The Vanderburgh County Medical Society in conjunction with the Board of Health of the city of Evansville held a public meeting at the Coliseum, April 11th, on the subject of health education. Exhibits were prepared by the city health board showing the various departments of health work in the city: the Anti-tuberculosis Society; Red Cross; Civic-Municipal Division of the Chamber of Commerce; Health Center; U. S. Venereal Clinic; City Milk Inspection Bureau. During the day free vaccination and toxin-antitoxin immunization were given to anyone who was desirous of obtaining them. A considerable number availed themselves of this opportunity. In the evening Drs. J. E. Monger and William King, Health Commissioners of the states of Ohio and Indiana, respectively, talked on the responsibilities of doctors and health commissioners to the public. A large representative audience was in attendance.

It is the intention of the Vanderburgh County Medical Society to hold a second public meeting, later in the year, on the subject of cancer.

KEITH T. MEYER, M.D.,
Secretary.

INDIANAPOLIS MEDICAL SOCIETY

April 5, 1928.

The regular meeting of the Indianapolis Medical Society was held at the Athenæum, April 3rd, at 8:15 p. m.

Drs. Norman Beatty, J. M. Masters, Morris B. Paynter and Simon Reisler were elected to membership.

Program—Dr. B. R. Kirklin, Roentgenological Department, Mayo Clinic. Subject, "Pulmonary Malignancy."

Dr. Kirklin pointed out that most of the work done on primary cancer of the lung had been done in the last three years, and that during this period sixty-eight proved cases have been studied at the Mayo Clinic. He classified these cases as to origin—bronchogenic and parenchymal. The onset is usually characterized by a persistent, annoying cough with or without blood-tinged sputum, loss of strength and weight, with pain in about fifty percent of the cases. The physical findings are very indefinite because the lesions are centrally located. Laboratory findings showed nothing characteristic. The roentgenological study was considered the most important phase of the examination. Stereoscopic films show a uni-lateral density extending out from the hilum and infiltrating into the parenchymal lung tissue. Obstructive atelectasis is a common complication and produces clouding or massive density of lobular or lobar type. The parenchymal type is found less often and presents definite infiltrating densities in any part of the parenchymal field. In the advance stage, especially if there has been central necrosis with secondary infection, a massive atelectasis or pleural effusion, the origin of the cancer cannot be determined clinically and differential diagnosis is exceedingly difficult. The bronchoscopic examination with removal of a section for pathological examination is the most important phase of the examination in establishing a diagnosis of pulmonary malignancy of the bronchogenic type. All cases have proved rapidly fatal, the bronchial type being of a higher grade of malignancy than the parenchymal. Death usually results from metastasis. Lantern slides of the roentgenograph showing type, distribution and complication with simulating non-cancerous cases, were shown.

Dr. James H. Stygall discussed pulmonary cancer from the internist's standpoint.

Dr. Wm. F. Molt discussed it from the bronchoscopist's viewpoint.

Dr. W. D. Gatch presented a series of chest films of a case seen within the past year.

CHESTER A. STAYTON, Secretary.

HOWARD COUNTY MEDICAL SOCIETY

April 27, 1928.

Dr. R. G. Leland, of Chicago, assistant secretary of the American Medical Association, addressed an audience at the First Congregational Church of Kokomo on Sunday evening, April 22, upon the subject, "Social Welfare Work Among Children and School Inspection." The society sponsored this meeting as the opening gun in a campaign for adequate health inspection in the schools of Howard County.

ELTON R. CLARKE, M.D.,
Secretary.

FOUNTAIN-WARREN COUNTY MEDICAL SOCIETY

The Fountain-Warren County Medical Society met at Kingman, Indiana, as guests at dinner of the Kingman physicians. Dr. Alfred Henry of Indianapolis presented a paper on "Early Diagnosis of Tuberculosis." Dr. A. C. Hally reported a case of Diverticulum of Jejunum, the sixth case of its kind ever recorded as diagnosed by x-ray; operation by Dr. A. M. Miller, who described his operation and results shown by x-ray.

Respectfully,
A. L. SPINNING, M.D., Secretary.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books received since April 1, 1928:

INTERNATIONAL CLINICS. A quarterly of illustrated clinical lectures and especially prepared original articles. Edited by Henry W. Cattell, A.M., M.D., Philadelphia. Volume I, thirty-eighth series. J. B. Lippincott & Co., Philadelphia and London, 1928.

DIABETES AND ITS TREATMENT BY INSULIN AND DIET. By Orlando H. Petty, M.D., professor of diseases of metabolism in the Graduate School of Medicine, University of Pennsylvania, etc. Introductory foreword by John B. Deaver, M.D. 150 pages. Cloth. Price $2.00. F. A. Davis & Company, 1928.

PRACTICAL DIETETICS IN HEALTH AND DISEASE. By Sanford Blum, M.D., head of department of pediatrics. San Francisco Polyclinic and Postgraduate School. Third revised and enlarged edition. 380 pages. Cloth. Price $4.00. F. A. Davis Company, 1928.

LOBAR PNEUMONIA. By L. R. Sante, M.D., St. Louis. 137 pages. Cloth. Price $3.00. Paul B. Hoeber, Inc., 1928.

MECHANICS AND CHEMISTRY OF THE HUMAN BODY. By O. Boto Schellberg. 50 pages. Illustrated. Cloth. Price $1.00. Schellberg Institute, 1928.

CARDIAC ARRHYTHMIAS. Clinical features and mechanism of the irregular heart. By Irving R. Roth, M.D. 210 pages with eighty illustrations and five tables. Cloth. Price $7.50. Paul B. Hoeber, Inc., 1928.

PHYSICAL DIAGNOSIS. By W. D. Rose, M.D., associate professor of medicine, University of Arkansas. Fifth edition. Profusely illustrated. 819 pages. Cloth. Price $10. C. V. Mosby Company, 1928.

HEART DISEASE. By Harold E. B. Pardee, M.D., assistant professor of clinical medicine, Cornell University Medical School. 120 pages. Cloth. Price $1.50. Lea & Febiger, 1928.

DIAGNOSIS OF DISEASE. By Hobart Amory Hare, B.Sc., M.D., LL.D., professor of therapeutics and diagnosis in the Jefferson Medical College of Philadelphia. Ninth edition, thoroughly revised. Illustrated. 528 pages. Cloth. Price, $5.50. Lea & Febiger, 1928.

GYNECOLOGY FOR NURSES. By Harry Sturgeon Crossen, M.D., F.A.C.S., professor of clinical gynecology, Washington University Medical School. 281 pages. Profusely illustrated. Cloth. Price $2.75. C. V. Mosby Company, 1928.

CLINICAL ASPECTS OF THE ELECTROCARDIOGRAM. By Harold E. B. Pardee, M.D. Second edition, revised. 242 pages. Illustrated. Cloth. Price $5.50. Paul B. Hoeber, Inc., 1928.

STRABISMUS: ITS ETIOLOGY AND TREATMENT. By Oscar Wilkinson, A.M., M.D., D.Sc., surgeon-in-chief of Washington Eye and Ear Hospital, Washington, D. C. 240 pages. Illustrated. Cloth. Price $10.00. C. V. Mosby Company, 1928.

Reviews:

CLINICAL LABORATORY PROCEDURES: By George L. Rohdenburg, M.D., director of laboratories, Lenox Hill Hospital; consulting pathologist, Lincoln Hospital, Misericordia Hospital, Beth Davis Hospital, New York. Cloth. 266 pages, price $3.25. The MacMillan Co., New York.

The present volume is a collection of laboratory methods which in the hands of the writer have shown their relative simplicity and clinical accuracy over a period of years of actual use. Where several methods are known or are in common use, that one has been arbitrarily selected which from practical experience the author recommended. Some knowledge of laboratory procedure on the part of those using the volume is presupposed. An effort has been made to present concisely such procedures as are frequently undertaken in routine work.

ABSTRACTS

PROBLEM OF EXERCISE FOR CHILDREN WITH HEART DISEASE

William St. Lawrence, New York (*Journal A. M. A.*, Dec. 31, 1927), says that from the standpoint of functional capacity, children with cardiac involvement tend to divide themselves into three groups: Class 1: Those with a normal exercise tolerance who are able to pursue the physical activities of normal children with no greater circulatory reaction. Class 2: Those with a diminished exercise tolerance who suffer from excessive circulatory reaction for the work performed. Class 3: Those with severe cardiac failure (decompensation) whose hearts are unable efficiently to meet the circulatory needs at rest in bed and hence have no exercise tolerance. The temperature as an indication for the institution of exertion has been found to be trustworthy. After the temperature has remained normal for ten consecutive days, in almost all instances rapid headway may be made. At first these children may be treated much as convalescent patients from any severe infection, being allowed increasing periods out of bed and later, beginning with a few steps, more and more exertion until they are able to go about the ward or bedroom with ease. The exercise tolerance tends to increase rapidly until considerable exertion is possible, and in one or two weeks these children are able to walk up one flight of stairs without excessive circulatory reaction.

LOCAL MEDICAL SOCIETY AND PUBLIC HEALTH

G. A. Carpenter, Kent Darrow and Arthur C. Morris, Fargo, N.D. (*Journal A. M. A.*, Jan. 21, 1928), detail the results of the active participation of a local medical society in the organization and guidance of a community health program. The Cass County Medical Society, representing the physicians of Fargo, N. D., has co-operated actively in a community health program since 1923. The medical society has given advice and assistance to the health officer and the child health demonstration through

the medium of advisory committees appointed by the medical society. Of twenty physicians questioned in 1927, ten, including physicians primarily interested in pediatrics, obstetrics and internal medicine, have noted an increased interest in health among their clientele. Fargo's health score, based on the American Public Health Association appraisal form, has increased from 320 in 1922 to 814 in 1926. That active preventive practice is increasing in Fargo seems certain. A limited number of adults are presenting themselves for periodic examination and health advice. There is a constant demand for health service by pregnant women. A recent survey of 522 prenatal cases shows that in 50 per cent the women consulted their physicians at or before the sixth month of pregnancy, and that only twenty-nine waited until labor began before calling a physician. The known measures of health supervision and disease prevention are available and being used for children. The services already initiated by the medical profession have been given an added stimulus by this united effort, with official and nonofficial health agencies participating, in such a way that the whole health movement in Fargo appears to have been put on a sound and, it is to be hoped, a lasting basis. Without such unity of purpose and understanding, neither the medical profession nor the health agency can accomplish as much as both have a right to expect in furthering the health interests of the community.

OBESITY

Louis Bauman, New York (*Journal A. M. A.*, Jan. 7, 1928), describes the modus operandi of ambulatory clinic established for the purpose of advising and following adipose patients. The personnel consists of a dietetian, a clerical aide and a physician. The time allotted is from two to three hours of one morning each week. Patients are referred after a routine history has been taken and physical, urine and blood examinations have been made. The majority of the patients were women. While constitutional factors were present in some, lack of balance between ingestion of food and expenditure of energy was the prevailing cause of fat storage. Obesity frequently followed lactation, the mother having too zealously followed the advice "to eat plenty of nourishing food in order to furnish milk for the baby." In others, adiposity followed convalescence from operation or prolonged illness. Certain nationalities habitually consume quantities of high calory foods. The southern Italian, for example, liberally indulges in macaroni and olive oil; the Czechoslovakian eats considerable rye bread, potato dumplings and certain kinds of cake. It is difficult to wean foreign patients from these so-called national dishes. With regard to the prevention of obesity, mothers should be informed that overeating is a habit which may be acquired during childhood, often through the efforts of overindulgent parents. Treatment consisted of a low calory diet, exercise and thyroxin in selected cases. The daily food allowance contained approximately 100 Gm. of carbohydrate, 70 of protein and 60 of fat. In hypertension, the protein intake was lowered and salt was also restricted; in patients with cardiac embarrassment, the water and salt intake was reduced. The exercise advised was daily walking of two miles in forty-five minutes or less, or calisthenics lasting ten minutes morning and night. It was apparent that ordinary housework could not replace systemic exercise. Thyroxin, 0.0008 Gm. daily, was administered to selected patients. No untoward effects were noticeable. The patient was warned to discontinue the hormone in the event of palpitation, cardiac pain, dyspnea or nervousness.

CLINICAL LABORATORY SERVICE IN THE UNITED STATES

STATEMENT BY THE COUNCIL ON MEDICAL EDUCATION AND HOSPITALS OF THE AMERICAN MEDICAL ASSOCIATION

During the last decade there has been much discussion in medical and laboratory journals and particularly on the platform of medical and laboratory conventions, regarding the status of the clinical laboratories of the country. Especially it was regretted that the practice of clinical pathology, regarded as one of the medical specialties, has fallen into disrepute. The fact was lamented that the laboratory work had fallen into the hands of lay technicians and become the toy of persons who had a purely commercial point of view and very little training for the work. Much disgust and quite a strong note of despair was sounded by those few members of the medical profession who had championed the cause of clinical pathology and had adopted that specialty as a life work.

Many letters were received at the office of the American Medical Association from practitioners of pathology and leaders in medicine regretting the drift toward lay commercialism, and urging that something be done to counteract it. What to do about it was a question. Organizations of chemists were interested because some of their members ran laboratories. Likewise organizations of clinical pathologists, bacteriologists, and of the medical profession were equally interested. Some of these organizations working alone undertook to investigate and to standardize the practice of clinical pathology, hoping to check the drift of that practice into the hands of technicians and restore it to its rightful place as a medical specialty.

CO-OPERATION EFFECTED IN 1923

The necessary co-operation of the laboratory and medical organizations was brought about in 1923 at the annual meeting of the American Medical Association in San Francisco. At that time delegates sent by the American Chemical Society and the American Association of Pathologists and Bacteriologists separately petitioned the American Medical Association to establish some supervision over clinical laboratories. This led to the appointment of three committees representing the American Chemical Society, the American Association of Pathologists and Bacteriologists, and the Council on Medical Education and Hospitals. At a joint meeting of these committees in Chicago early in 1924, after much deliberation, certain basic principles underlying sound laboratory service were agreed upon which stressed especially a qualified bona fide director as the prime essential.

The first steps were: (a) to secure a complete list of laboratories in the country; (b) the preparation of a schedule of essentials in an improved clinical laboratory, and (c) the preparation of a questionnaire by which the essential facts regarding each laboratory could be obtained. Each of those measures was carried out with the advice and co-operation of fifty or more clinicians and others expert in laboratory work, including the committeemen of the above-named organizations, and by the officers of the American Society of Clinical Pathologists which very early showed an interest and from which the Council has received a hearty co-operation.

After being revised and adopted by all parties interested, the questionnaire was mailed to all the laboratories of the country and a most hearty response was received. A complete report of the survey, "Essentials of an approved Clinical Laboratory," and a preliminary list of laboratories which appeared to be fully complying with those "Essentials," were published in the Hospital Number of the *Journal* for April 3, 1926. The facts as published were submitted to the House of Delegates of the American Medical Association at the Dallas session in 1926 and approved by that body.

To assist in giving as fair consideration as possible to each application for approval, a strong committee of laboratory experts was formed in every state or section of the country. Those committees aggregate one hundred and twenty individuals representing, as equally as possible, the co-operating organizations and hence the interests of the laboratory profession. Under the direction of the Council, each committeeman makes his investigation and renders his report or advice independently of other committeemen in the same district.

The Council lends all possible assistance to laboratories whereby they may become eligible for admission to the

accepted list. Every laboratory that makes a report and signifies a desire to conform to the requirements, is informed in regard to any deficiencies. The spirit of this movement all the way through is constructive. Anyone who knows the condition of the laboratory field at the time this survey was begun, would not expect very telling or spectacular results to be shown by this time; nevertheless, there are ample reasons for believing that actual improvements are being made: (1) A number of laboratories formerly run by technicians and only nominally under "medical' directors, have come under the ownership and actual control of clinical pathologists of high professional standing and ripe experience; (2) a number of laboratories under the control of technicians have gone out of business; (3) the "Essentials" have been published repeatedly and thus brought to the attention of all persons working in the field of clinical pathology; (4) there is an increased demand for pathologists to man the clinical laboratories of the country; (5) the director of the Mayo Foundation says that the salaries offered the pathological graduates of the Foundation are double those offered to other graduates of the Foundation; (6) the feeling of unsteadiness indicated in the discussions of a few years ago has subsided to a considerable degree, and there is a more hopeful attitude on the part of the clinical pathologists themselves.

FUTURE OUTLOOK

The movement is still in its beginning, but a good start has been made. To what extent doctors have actually discontinued sending specimens to unapproved laboratories and are sending them to approved laboratories is not known. The educational results, however, are becoming increasingly evident. In order to secure the best analyses for the benefit of their patients as well as to best conserve the interests of the medical profession, physicians should refuse to have their work done at laboratories conducted under the direction of non-medical individuals. Much depends, also, on the continued hearty support of the various organizations and individuals who operate in the laboratory field. That this is already assured is indicated by the promptness with which laboratories are filling out and returning the form that has recently been mailed out by the Council on Medical Education and Hospitals for a complete and needed resurvey of laboratory service.

CASE OF LEAD POISONING RESULTING FROM USE OF SNUFF

Walter Bauer and Marion W. Ropes, Boston (*Journal A. M. A.*, March 10, 1928), report the case of a man, aged 59, who had enjoyed good health until one year before his entrance to the hospital. At this time he suffered from vomiting, constipation, and severe cramplike pain confined to the lower half of the abdomen. There were no other associated symptoms. This attack lasted three days; complete relief was obtained from thorough purgation. He had had five similar attacks during the year, each time suffering from the same symptoms, and he always obtained complete relief by catharsis. Two weeks prior to entry he was again troubled with vomiting, obstinate constipation, and severe lower abdominal cramplike pains, and had not received any relief from catharsis. He had never had any venereal disease. He said that he had consumed from one to two ounces of moist snuff tobacco daily for at least twenty-five years. He usually snuffed the tobacco into his nose but he also admitted chewing it from time to time. On examination, large amounts of lead were found in the stools and urine. Close questioning did not elicit any possibility of lead exposure in his occupation. He was fairly certain he had never used water from lead pipe. This led to a suspicion that the snuff was the possible cause of the plumbism. The two brands of moist snuff tobacco that he was accustomed to using were then examined for lead. One sample was found to contain 0.9 mg. per ounce and the other 0.8 mg.

HEALTH EXAMINATIONS AND PHYSICIAN

J. Rosslyn Earp, Yellow Springs, Ohio (*Journal A. M. A.*, Feb. 4, 1928), relates his experience in making examinations of all applicants for admission to Antioch College. These examinations are made by the applicant's family physician. When the forms are returned by the physician they are carefully read and a report is made both to the admissions committee and to the personnel department which assigns industrial work. The form is then filed, and nobody, not even the president of the college, is given access to these files. Soon after he or she reaches college, the freshman comes to Earp's office for an interview. The purposes of this interview are to follow up the observations of the physician, reinforce his recommendations, insure that the student is well adjusted to his new environment, and engage his co-operation in the care of his health. The most astonishing deficiency in the returns is the failure of the physician to make any positive health recommendations. In the last 100 reports received, however, there were seventy-two in which no positive advice had been given by the physician. These seventy-two students included some who had never been vaccinated, and others who were evidently undernourished or suffered from hay-fever, headaches, constipation and other remediable defects. Even when advice has been given, it frequently failed to cover all the complaints registered in the form. Earp says that the main defect in periodic health examinations, as they are conducted today, lies in the fact that the examining physician is still more interested in advanced symptoms of manifest disease than in those lesser disorders of function which call not for curative treatment but for prophylaxis.

DISTRIBUTION OF BORIC ACID IN HUMAN ORGANS IN SIX DEATHS DUE TO BORIC ACID POISONING

In six fatal cases of boric acid poisoning, occurring in infants, William D. McNally and C. A. Rust, Chicago (*Journal A. M. A.*, Feb. 4, 1928), investigated the distribution of boric acid in the human tissues. The average percentages found in the tissues assayed (presented in an accompanying table) indicate that the brain and liver accumulate about the same and the higher percentages of boric acid; namely, 0.210 and 0.182 per cent, respectively. The bowel contained an intermediate amount of 0.102 per cent, while the heart, lungs, stomach, kidneys and diaphragm contained the lower percentages, 0.085, 0.0516, 0.0271 and 0.0124 per cent, respectively. The lower amount of boric acid in the stomach tissue (0.0358 per cent) may indicate that the acid was entering the systemic circulation through this channel by a process of osmosis rather than by means of the bowel (0.1023 per cent) tissue.

TRUTH ABOUT MEDICINES

PROPAGANDA FOR REFORM

GRAPEFRUIT AS A "PATENT MEDICINE."—In October, 1927, the *Journal of the Michigan State Medical Society* printed an utterly preposterous article entitled "The Therapeutic Value of Hill Grown Grapefruit." Inadvertently, an abstract of this appeared in the *Journal of the American Medical Association*. There is not the slightest scientific evidence that any kind of grapefruit has any curative virtues in diabetes. The article mentioned vaunts the alleged potency of a special brand of grapefruit; it refers to the case of a Dr. Roy who has been exploiting himself in this connection for several years and now, apparently, it has led to a real-estate promotion and to the foundation of a sanatorium company by the Michigan physician.—(*Jour. A. M. A.*, March 3, 1928, p. 696).

THE TUBERCLECIDE FRAUD.—Charles F. Aycock, "Consumption Cure" faker, has been debarred from the mails. He has for years sold a fraudulent "cure" for consumption called "Tuberclecide." This nostrum was exposed

seventeen years ago; at that time Tuberclecide sold at $15 for a two-ounce bottle and was found by the A. M. A. Chemical Laboratory to be essentially a solution of creosote, or guaiacol, in olive oil. Eleven years ago he was prosecuted in California, but the case was dismissed. Since then, Aycock has continued to defraud the tuberculous public, until finally the postal authorities have proceeded against him for fraudulent use of the United States mails. About January 1, 1928, a fraud order was issued against the Aycock Medical Institute. Aycock Medicine Company, Aycock Medical Company and Charles F. Aycock. There is reason to believe, however, that Aycock is evading the order by doing business under the name "Tuberclecide Institute," 402 Delta Building, Los Angeles, California.—(*Jour. A. M. A.*, March 3, 1928, p. 710).

Pancrepatine.—The Anglo-French Drug Co., which markets "Pancrepatine A. F. D.," has not requested an examination of the preparation by the Council on Pharmacy and Chemistry. "Pancrepatine A. F. D." is stated to be "a combination of a Special Extract of the Pancreas and Hepatic Extract * * * " It is claimed that the oral administration of the preparation results in "Reduction of Glycemia" and "reduction and sometimes total disappearance of glycosuria." There is no convincing evidence to show that any preparation taken by mouth is an effective means of producing the characteristic action of insulin.—(*Jour. A. M. A.*, March 3, 1928, p. 714).

Auriculator Not Acceptable.—The Council on Physical Therapy reports unfavorably on the Auriculator, submitted to the Council by Dr. Maury M. Stapler, Macon, Ga. It is stated to be a device for treating certain classes of deafmutism. The apparatus is a slightly different adaptation of a principle that has long been employed in the treatment of tubotympanic adhesive processes. The Council declares the Auriculator inadmissible for inclusion in the list of devices for physical therapy which are acceptable (1) because no scientific evidence has been presented to warrant the claim that it can be used successfully in treating deafmutism and (2) because the descriptive material submitted with the device contains unscientific and incorrect statements as to the causes of deafmutism.—(*Jour. A. M. A.*, March 10, 1928, p. 767).

Barbital Addiction.—The wide use of hypnotic preparations by the public has brought new problems for solution. When a single practitioner can report a hundred cases of acute poisoning or chronic addiction with one of the newer hypnotic drugs, the situation is serious. Barbital, introduced as veronal, has an increasing lay popularity for self administration. Its habit-forming propensities are sufficiently well recognized to merit the special designation of barbitalism or veronalism. A host of proprietary hypnotics now on the market may induce in greater or less degree the same result. Addiction to barbital appears not to stop with the production of moderate euphoria. Judgment, orientation as to time, and insight are probably the most severely harmed of the psychic faculties and are the last to clear up in convalescence. The "safe" hypnotics may become menacing to the public welfare.—(*Jour. A. M. A.*, March 10, 1928, p. 769).

Vitamins A and D in Cod Liver Oil.—Accumulated evidence seems to have established the fact that vitamin A is not identical with the antirachitic factor; as a consequence, vitamin D has been postulated. Work has been published which shows that some cod liver oils, rich in vitamin A, were poor in vitamin D, and that others rich in vitamin D were poor in vitamin A. The importance of this matter may be appreciated when it is pointed out that some commercial firms whose products have a satisfactory vitamin A content claim, *ipso facto*, a satisfactory content of the antirachitic factor, vitamin D. The Council on Pharmacy and Chemistry has previously attacked this fallacy. In the new section on Vitamin Foods to appear in the chapter on Medicinal Food in New and Nonofficial Remedies, 1928, the Council states that it does not feel justified in requiring any specific test or standard of antirachitic potency, but it announces the policy of encouraging manufacturers to adopt and publish such methods of testing as will enable them to guarantee a vitamin D potency for their products. For products admitted to New and Nonofficial Remedies the Council permits no claim of vitamin potency unless it is backed up by adequate tests for the kind of potency claimed.—(*Jour. A. M. A.*, March 10, 1928, p. 770).

The Vit-O-Net Quackery.—Credulity moves in waves and quackery rides on the crest of the wave. The 1927-1928 brand of medical humbug is Magnetism with a capital "M." A concern known as the Vit-O-Net Corporation (previously the Vit-O-Net Manufacturing Co.), and having headquarters in Chicago, puts out a large sized electric heating pad or blanket which sells for $102.50. The concern that exploits it evidently realizes that for one person that would buy its device as a heating pad, there are fifty who will buy it as a cure for whatever ails them. From the testimonials and claims made by the exploiters it appears that the Vit-O-Net blanket cures cancer, arthritis, Bright's disease, eczema, neuritis, paralysis, anemia, low blood pressure, high blood pressure, goiter, epilepsy, asthma, prostatic trouble, deafness, and various other conditions. The Vit-O-Net blanket is a convenient and expensive way of applying continuous heat to the body. Further than this one cannot truthfully go. The curative value of the Vit-O-Net blanket is that of heat which differs not at all from that developed from a hot water bottle or of a hot brick wrapped in a sock!—(*Jour. A. M. A.*, March 10, 1928, p. 789).

Epinephrine and Ephedrine in Relation to Blood Pressure.—The action of ephedrine on the circulation is different from that of epinephrine. While the latter is a powerful heart stimulant, ephedrine is a direct depressant to the heart. A heart that has been depressed by continued low blood pressure is so sensitive to the depressant action of ephedrine that the poor condition of the circulation may be aggravated by it. It is also much feebler as a vasoconstrictor than is epinephrine. Hence, as a circulatory stimulant, ephedrine has been a disappointment.—(*Jour. A. M. A.*, March 10, 1928, p. 791).

Relative Safety of Sedative Drugs.—Sulphonmethane (sulphonal) and sulphonethylmethane (trional) have to a large extent been superseded by phenobarbital (luminal) and barbital (veronal), especially because the sulphonmethanes are apt to make the patient drowsy the day after the ingestion, and are liable to produce an alteration in the blood which manifests itself by hematoporphyrinuria. Barbital is a relatively safe but feeble hypnotic which may be preferred to all others when a mild effect suffices. Phenobarbital is a much more potent drug. It is safe when given in a dose of from 0.1 to 0.2 Gm. It is contraindicated in the presence of marked asthenia and in nephritis.—(*Jour. A. M. A.*, March 10, 1928, p. 792).

BiSoDol.—The advertising of the "BiSoDol Company" states that BiSoDol is composed of "Bismuth Subnit.—Magnes. Carb.—Sodium Bicarb.—Carica Papaya—Diastase—Ol. Menth-Pip." but contains no information in regard to the amount of each ingredient. The Council on Pharmacy and Chemistry has not examined the preparation nor has the A. M. A. Chemical Laboratory considered it worth while to analyze this "shotgun" mixture.—(*Jour. A. M. A.*, March 10, 1928, p. 793).

Argyrol Omitted from N. N. R.—Argyrol is included in New and Nonofficial Remedies as a brand of mild silver protein, U. S. P. At the expiration of the period for which Argyrol stood accepted, the Council on Pharmacy and Chemistry informed the A. C. Barnes Company that the advertising claims for therapeutic efficacy of this product went beyond those of mild antiseptic or protective value allowed for mild silver protein and asked that the firm present evidence to substantiate these claims; the firm was also informed that in order to permit the continued acceptance of the product the labels and advertising must bear the pharmacopeial title, mild

silver protein, as a synonym. The firm presented no satisfactory evidence for the therapeutic claims in question and refused to mention the pharmacopeial name on the labels and advertising of Argyrol. The Council, therefore, voted to omit Argyrol from New and Nonofficial Remedies and authorized publication of its report explaining this action.—(*Jour. A. M. A.*, March 17, 1928, p. 849).

PROPRIETARY PREPARATIONS AND PROPRIETARY NAMES.—The rule of the Council on Pharmacy and Chemistry of the American Medical Association provides that, when a proprietary substance is admitted to the U. S. Pharmacopeia, it will be retained in New and Nonofficial Remedies only if the official name is given prominence on the labels and in the advertising. The justice of this rule concerning proprietary names cannot be questioned. It is in the interest of scientific medicine and of medical progress. The history of Argyrol, which the Council has been obliged to omit from New and Nonofficial Remedies for conflict with this rule, is another example of the manner in which clinical evidence, none too carefully obtained, may boost a new remedy into popularity beyond its due. The promoter of a proprietary preparation, riding on the crest of a wave of popularity, is seldom willing to come down to the level of the quiet sea when the storm subsides. The Council has examined calmly and dispassionately the therapeutic claims made for Argyrol and has been unable to find evidence for some claims which it terms essentially misleading. Furthermore, the manufacturer is apparently unwilling to adopt the pharmacopeial synonym for it. The insistence on this synonym is important that physicians may fully comprehend the nature of the substance that they are using. The first duty of anyone working in the field of medicine, be it investigator, teacher, physician or manufacturer, is to the public that is being served. This policy has been fundamental in compelling the omission of Argyrol.—(*Jour. A. M. A.*, March 17, 1928, p. 855).

MORE MISBRANDED NOSTRUMS.—The following products have been the subject of prosecution by the Food, Drug and Insecticide Administration of the United States Department of Agriculture which enforces the Federal Food and Drugs Act: Pildoras Ovaricura (Flar Medicine Company), containing iron sulphate and plant material, including aconite, aloe, ginger and cinnamon. Cerebrotono (Flar Medicine Company), containing calcium, sodium, potassium and iron glycerophosphates, with plant extractives, alcohol and water. Pildoras Ferrogenas (Flar Medicine Company), containing iron and potassium carbonate and sulphate comparable to Blaud's pills. Zovia (Zovia Wonder Water Company), a solution of Epsom salt in water. Elixir Eneglotaria (Eneglotaria Medicine Company), consisting essentially of mercury and potassium iodides, sarsaparilla extract, alcohol and water. Jarabe de Guayaco Eneglotaria (Eneglotaria Medicine Company), consisting essentially of mercury and potassium iodides, guaiacol, sugar, alcohol and water.—(*Jour. A. M. A.*, March 17, 1928, p. 872).

ABSORPTION OF INSULIN FROM THE ALIMENTARY TRACT.—In recent experiments advantage has been taken of the antitryptic effect of blood serum to protect insulin given by oral paths from pancreatic digestive destruction. Observations on a series of depancreatized dogs prove that insulin protected by blood serum from the proteolytic destruction of the digestive enzymes can be absorbed in significant amounts from the alimentary tract. While the experiments are promising, this is not the story of a completely dependable method of oral therapy; the results do not establish the usefulness of the host of proprietary insulin substitutes proposed for oral use.—(*Jour. A. M. A.*, March 24, 1928, p. 985).

MATTHEWS' PHOS-HEPATIC EXTRACT AND LIVERMEAL.—No product of the Livermeal Corporation which markets "Livermeal" and "Matthews' Phos-Hepatic Extract" has been accepted for New and Nonofficial Remedies nor has the firm requested the Council on Pharmacy and Chemistry to consider any product. Apparently the Livermeal Corporation is "pushing" its shotgun proprietary, "Matthews' Phos-Hepatic Extract," which is claimed to contain the "extractive principles" of fresh beef liver in "combination" with sodium glycerophosphate and "carefully selected carminatives and digestants." So far, the Council on Pharmacy and Chemistry has accepted but one liver extract preparation: Liver Extract No. 343.—(*Jour. A. M. A.*, March 24, 1928, p. 997).

RADIO-REM OMITTED FROM N. N. R.—The Council on Pharmacy and Chemistry reports that a report announcing the omission of Radio-Rem was prepared in 1925, but not published at the time because the Radium Ore Revigator Company stated that it had purchased the Radium Therapy Corporation, which controlled the Radio-Rem outfits and that these were no longer marketed. Recently, the Council received a letter from the Radium Ore Revigator Company which suggested that the former recognition of Radio-Rem may be used as a means of exploiting the "Revigator (Health Spring Strength)". The Council authorized publication of its report explaining the omission of Radio-Rem from New and Nonofficial Remedies. The report explains that Radio-Rem is an apparatus designed for the production of radioactive drinking water, marketed by the Radium Therapy Corporation, San Francisco, California. The Council found that there was a close connection between the firm which marketed the Radio-Rem outfits and the firm which exploited the Radium Ore Revigator, an apparatus exploited to the public with misleading claims. The Council directed the omission of the Radio-Rem outfits from New and Nonofficial Remedies because they were used to further the sale of the Radium Ore Revigator, which is exploited to the public with false claims for the therapeutic efficiency of radium emanation.—(*Jour. A. M. A.*, March 31, 1928, p. 1038).

AMMONIUM ICHTHYOLATE-DAYTON AND DAYTOL NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that in 1925 it informed the Dayton Chemical Company, manufacturers of Ammonium Ichthyolate-Dayton, that this product could not be accepted because the advertising claims were unwarranted and that the firm took no action to make its product acceptable. From advertising sent out by the Dayton Chemical Company for "Daytol" it is evident that this product is essentially similar to Ammonium Ichthyolate-Dayton and the Council declared Ammonium Ichthyolate-Dayton and Daytol unacceptable for New and Nonofficial Remedies, because the therapeutic claims made for them are unwarranted. When the report of the Council was sent to the Dayton Chemical Company a reply was received from the Daytol Company, as successor to the Dayton Chemical Company. The firm stated that it wished to make Daytol acceptable for New and Nonofficial Remedies but that almost two years would be required to secure the needed evidence. The firm gave no indication that its propaganda would be discontinued in the meantime; therefore, the Council authorized publication of its report.—(*Jour. A. M. A.*, March 31, 1928, p. 1039).

THE KIRKPATRICK CONSUMPTION CURE FAKE.—One George Kirkpatrick, an obscure veterinarian of Portland, Oregon, exploits a quack consumption cure, "Pul-Bro-Tu." The mayor of Portland wrote a letter favorable to the preparation. The city council of Portland decided that a committee should be appointed to investigate the "cure" and the members of this committee were named by the mayor. The committee filed a report declaring unanimously that the Kirkpatrick nostrum was "without value in the treatment of tuberculosis and its use, as such, constitutes a menace." When the mayor testified before the committee, he declared, in effect, that his enthusiasm for Pul-Bro-Tu was based on the eulogistic reports he had received regarding the nostrum from Drs. Ralph C. Walker and Carl T. Ross. The committee brought out that Dr. Walker was a stockholder in the Kirkpatrick Remedies Company, and that both Dr. Walker and Dr.

(Continued on adv. page xx)

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Tillyer Lenses
Accurate to the very edge
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TRUTH ABOUT MEDICINES

(Continued from page 232)

Ross profited through their tie-up with the Kirkpatrick outfit.—(*Jour. A. M. A.*, March 31, 1928. p. 1041).

SANATOLOGY "THE ONLY SCIENCE OF HEALTH."—"Sanatology" is a new cult. In 1927, Percival Lemon Clark went before a committee of the Legislature of Illinois in behalf of "House Bills Nos. 296, 297, and 411." These bills were for the purpose of getting legal recognition of the cult, Sanatology. Dr. Clark has advertised through newspapers and by radio. He sums up his attainments, thus: "I cure the sick, cure the desperately sick, cure asthma, cure rheumatism, cure hay fever, cure goiter, and all the rest of the 'incurable' diseases." Dr. Clark's merchandise accessories comprise such products as "Dr. Clark's Dextrinized Wheat Health School Bran," "Cereal Bran," "Cracked Wheat," "Steel Cut Oatmeal" and "Dr. Clark's Cooked Whole Wheat." Then there is a "Sanatology Blower"; the "Sanatological Enema Bag and Attachments"; the "Sanatological Oil" and the "Health School Laxative Tablet." Dr. Clark's *magnum opus* is "How to Live and Eat for Health," which is a book of 240 pages, devoted mainly to Dr. Clark's peculiar theories, dietetic and medicinal, and incidentally, to advertising Percival Lemon Clark and the Health School.—(*Jour A. M. A.*, March 31, 1928, p. 1060).

"LYSOL".—Lysol is not the discovery of any one person, but was evolved gradually and is a good illustration of the way in which manufacturers appropriate the discoveries of others, develop them and turn them to proprietary use. The ill-deserved patent protection for Lysol happily expired long ago and the product can now be made by anyone. This cresol-soap solution has been admitted to pharmacopeias, not under the original name "Lysol" but under descriptive names such as that in the United States Pharmacopeia—"liquor cresolis compositus." In 1912 the Council on Pharmacy and Chemistry published a report in which objection was made to the method of exploitation which tended toward its indiscriminate and ill advised use by the public. The use of cresol in the form of the pharmacopeial product, liquor cresolis compositus, rather than under a proprietary name is in the interest of rational therapy.—(*Jour. A. M. A.*, March 31, 1928, p. 1063).

SEROSALINE.—From the advertising of the Davis-Johnson Company it appears that "Serosaline" is similar to the preparation Sulcitacium, which the Council on Pharmacy and Chemistry found unacceptable for New and Nonofficial Remedies because its composition is not declared and because the therapeutic claims advanced for it are not supported by acceptable clinical evidence. While Sulcitacium was said to be indicated "in the treatment of Hypertension" and was administered orally, Serosaline is claimed to be "definitely effective in the various types of acute and chronic nephritis" and is to be administered intravenously. As in the case of "Sulcitacium," the advertising for "Serosaline" contains only vague and indefinite statements of composition. It is to be hoped that few physicians will assume the responsibility of administering intravenously a preparation the composition of which they do not know.—(*Jour. A. M. A.*, March 31, 1928, p. 1064).

TRANSKUTAN.—According to the advertising, "Transkutan" is being marketed by Transkutan, Inc., New York. Other advertising bears the name of P. L. Frailey. Neither Transkutan, Inc., nor P. L. Frailey has requested an examination of Transkutan by the Council on Pharmacy and Chemistry. The preparation is referred to in the advertising as a "brine combination of natural mineral springs and extracts of plants abounding in terpenes." It appears that the public is to be exploited by means of newspaper advertisements and, as is so often the case, that physicians are to be the unsuspecting promoters of this proprietary nostrum.—(*Jour. A. M. A.*, March 31, 1928, p. 1064).

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ORIGINAL ARTICLES

SPECIFIC TREATMENT OF SCARLET FEVER AND DIPHTHERIA*

WITH SPECIAL REFERENCE TO THE USE OF ANTITOXIN

PAUL S. RHOADS, M.D.

CHICAGO

In 1923 Dr. George F. Dick and Dr. Gladys H. Dick published the results of work which definitely established a specific hemolytic streptococcus as the cause of scarlet fever. All of Koch's postulates, including the experimental production of the disease (this time in man), were fulfilled. It is upon this fundamental discovery that the present effective methods of treatment of scarlet fever are based.

The years of systematic study preceding the actual proof of the etiological agent had led the Dicks to the conception of scarlet fever as a disease whose general manifestations, particularly the rash, are caused by a circulating toxin, while the streptococci, which caused the angina, remained localized in the throat. Repeated blood cultures made at various stages during the course of the disease gave no evidence of bacteremia playing a role except in severely complicated cases near death. On the other hand, by injecting relatively large doses of sterile toxin (the filtrate of four-day-old broth cultures of the streptococcus scarlatinæ) they were able to reproduce the typical symptoms of scarlet fever, including the nausea, vomiting, fever and rash in susceptible individuals.

The discovery of this specific toxin of scarlet fever enabled them to develop the following measure for combating the disease:

First: A skin test to determine which individuals are susceptible to scarlet fever and which are immune.

Second: A method of actively immunizing susceptible individuals so that they do not contract the disease on exposure.

Third: An antitoxin specific for scarlet fever for use after the development of the disease and to confer a rapid, temporary immunity on susceptible individuals who have been exposed to the disease.

Fourth: A method of recognizing scarlet fever streptococci.

These four applications of the discovery of the specific toxin together with the use of throat and nose cultures on blood agar plates furnish the means of controlling scarlet fever.

Skin Test: The skin test to determine susceptibility to scarlet fever is made by injecting intradermally exactly 0.1 cc. of a dilute, standardized solution of scarlet fever toxin. The injection is made on the anterior surface of the forearm at the junction of the upper and middle thirds. The test is observed twenty to twenty-four hours after it is made. This observation should be made in a bright light. An area of reddening 1.0 cm. or over in any diameter constitutes a positive reaction and indicates some degree of susceptibility to scarlet fever. The positive Dick reaction to scarlet fever toxin differs from the positive Schick reaction to diphtheria toxin in being more transient and showing no induration. Observations of the Dick test, made more than twenty-four hours after the injection is made, may not be reliable because the slightly positive reactions may disappear promptly. On the other hand the test should not be observed earlier than twenty hours after the injection. The positive reaction to scarlet fever toxin may vary from the faintest pink flush to an intense red according to the degree of susceptibility of the individual. The number of positive tests that have been interpreted as negative is large. This is particularly true of the more slightly positive reactions.

If the skin test solution is properly prepared, it is not necessary to use a control, for pseudo-reactions are uncommon. Correctly made and interpreted, the skin test has proved a reliable means of determining susceptibility to scarlet fever. Depending on the age and living conditions, the percentage of susceptible persons in different groups varies from twelve to ninety percent.

Active Immunization Against Scarlet Fever: Susceptible persons may be immunized against scarlet fever by the injection of graduated doses of sterile scarlet fever toxin. The following doses are recommended:

First dose,	500 Skin test doses
Second dose,	2,000 Skin test doses

*Presented before the meeting of the Lake County Medical Society, January 12, 1928.

Third dose, 8,000 Skin test doses

Fourth dose, 25,000 Skin test doses

Fifth dose, 80,000 Skin test doses

The injections are made subcutaneously in the upper arm at intervals of five to seven days. This dosage has been found to immunize more than ninety percent of susceptible persons to the point of an entirely negative skin test. Two weeks after the last immunizing dose, the skin test is repeated. Unless it is found to be entirely negative, the fifth dose is repeated.

Ricinoleated preparations of scarlet fever toxin and preparations put out for use in one, two, three, or four doses have not been found satisfactory.

Active immunization with scarlet fever toxin has not been carried on long enough to allow an accurate estimate of the duration of the protection afforded. The results available indicate that if large enough doses of toxin are employed, the immunity lasts for a period of years.

Scarlet Fever Antitoxin: Scarlet fever antitoxin is prepared from the blood of horses which have received gradually increasing doses of sterile scarlet fever toxin over a period of several months. The serum is separated, aged, refined and concentrated. With these procedures, it has been possible to reduce the incidence of serum reactions following the administration of scarlet fever antitoxin to a figure comparable to the incidence of serum reactions following the administration of other antitoxic, refined serums, such as diphtheria and tetanus antitoxin.

The potency of scarlet fever antitoxin is determined by its ability to neutralize the toxin. One neutralizing unit of scarlet fever antitoxin is the amount sufficient to neutralize one skin test dose of the toxin and hold it in combination forty-eight hours. The therapeutic dose of scarlet fever antitoxin should contain at least 300,000 neutralizing units and the prophylactic dose should contain 100,000 units.

The antitoxin is injected intramuscularly as soon as the rash begins to appear. It is advisable to give it even in mild cases because it is known that complications occur in mild as well as in more severe forms of scarlet fever. If the attack is severe and the patient very toxic, two therapeutic doses of antitoxin should be given at once, and more after eighteen to twenty-four hours if indicated. In puerperal scarlet fever, even more antitoxin is indicated. When the antitoxin is given early in the disease, a prompt fall in temperature and fading of the rash may be anticipated. The reports of the Dicks and of Gordon show that antitoxin, given early, shortens the febrile period and reduces the number and severity of complications and sequelæ. The tables following show the influence of scarlet fever antitoxin on complications.

(Tables given by Dick, G. F., and Dick, G. H.)

THERAPEUTIC RESULTS WITH CONCENTRATED SCARLET FEVER ANTITOXIN

J. A. M. A., 84:803 (March 14, 1925).

TABLE I.

RESULTS IN MODERATELY SEVERE CASES

	No. of Cases	Deaths	Post scarlatinal nephritis Percent	Otitis media Percent	Mastoiditis and otitis Percent	Severe cervical adenitis Percent
Control Series	35	0	8.5%	14.2%	8.5%	2.9%
Antitoxin Series	21	0	0	4.7%	0	0

TABLE II.

RESULTS IN SEVERE CASES

	No. of Cases	Deaths	Post scarlatinal nephritis Percent	Otitis media Percent	Mastoiditis and otitis Percent	Severe cervical adenitis Percent
Control Series	15	20%	20%	20%	20%	33.3%
Antitoxin Series	22	3.4%	0	6.8%	3.4%	3.4%

(Tables given by Gordon, J. E.)

TREATMENT OF SCARLET FEVER WITH STREPTOCOCCUS ANTITOXIN

J. A. M. A., 88:382 (Feb. 5, 1927).

MODERATE CASES

	No. of Cases	Deaths	Nephritis	Otitis Media	Mastoiditis	Severe Cerv. Adenitis	Arthritis
Control	242	0.4%	0.8%	7%	1.2%	19%	4.5%
Antitoxin	50	-------	-------	4%	-------	8%	2.0%

MODERATELY SEVERE CASES

	No.	Deaths	Nephritis	Otitis Media	Mastoiditis	Severe Cerv. Aden.	Arthritis
Control	101	-------	7%	16%	2%	45%	10%
Antitoxin	197	0.5%	2.5%	5%	5%	8%	3.5%

SEVERE CASES

	No.	Deaths	Nephritis	Otitis Media	Mastoiditis	Severe Cerv. Aden.	Arthritis
Control	24	25%	17%	43%	17%	48%	35%
Antitoxin	70	4.3%	3%	13%	3%	25%	3%
Total	367	28%	4.0%	12%	2.5%	28%	8%
	317	12%	2.2%	7%	0.9%	.12%	3%

Clinical Course:

	No. Cases	Duration of Eruption	Duration of Fever	Days in hosp. after 28th day of disease
Control	367	4.3	7.4	1,670
Antitoxin	317	3.8	6.2	631

	Uncomplicated		One complic.		Multiple complic.	
Control	161	44%	115	31%	91	25%
Antitoxin	210	66%	85	26%	25	8%

Scarlet fever antitoxin may be employed in prophylactic dosage of 100,000 neutralizing units to confer a rapid, passive immunity on susceptible persons who have been exposed to scarlet fever. Since the immunity thus conferred usually does not last more than ten days to two weeks, active immunization with the toxin should be started one week after the prophylactic dose of antitoxin is administered.

Handling of Contacts: In our experience the use of scarlet fever antitoxin prophylactically is not often necessary, if the contacts can be kept under observation. The healthy individuals who have been in contact with a case of scarlet fever should be examined carefully for evidences of sore throat or a beginning rash on the trunk. At the

AVERAGE DURATION IN DAYS OF COMPLICATIONS

TYPE OF CASE	Cervical Adenitis		Suppurative Otitis Media		Catarrhal Otitis Media		Mastoiditis		Primary Rhinitis and Sinusitis		Secondary Rhinitis and Sinusitis		Albuminuria		Nephritis		Arthritis	
	Number	Aver. Days	Number	Aver. Days	Number	Aver. Days	Number	Aver. Days	Number	Aver. Days	Number	Aver. Days	Number	Aver. Days	Number	Aver. Days	Number	Aver. Days
Moderate:																		
Control	46	10.9	17	26.8	24	5.9	3	6.7	9	8.6	13	14.8	3	5.3	2	12	11	9.2
Serum treated	4	6.0	2	18.5	3	3.7	0	---	1	28.0	1	25	3	10.0	0	---	1	5.0
Moderately Severe:																		
Control	45	16.4	16	41.4	20	7.5	2	14.5	16	13.6	20	17.9	6	13.3	6	25.2	12	6.6
Serum treated	16	9.0	10	21.5	13	6.2	1	5	18	10.8	3	30.7	6	11.3	5	11.6	7	10.1
Severe:																		
Control	11	16.5	7	49.6	2	8.5	4	17.8	6	19.7	2	17.5	0	0	3	18	8	7.3
Serum treated	16	9.3	8	14.5	9	6.6	2	5	21	11.4	3	9.3	2	20.5	1	22	3	3.7
Total:																		
Control	102	13.9	40	36.6	46	6.7	9	13.3	31	13.3	35	16.7	9	10.7	11	20.8	31	7.7
Serum treated	36	8.8	20	18.4	25	6.0	3	5	40	11.5	7	20.5	11	12.6	6	13.3	11	7.9

same time their temperatures should be taken. Should any of the findings point to a beginning illness a therapeutic dose should be administered without delay. However, if there are no evidences of sore throat or rash or fever, the antitoxin may be withheld. In this case it is best, if possible, to do Dick tests on the persons in question and at the same time take cultures on blood agar plates from the nose and throat. Next day one can learn from the results of these tests, first, whether or not the "contact" harbors hemolytic streptococci in his throat or nose; second, whether he is susceptible to scarlet fever. Even though the individual in question may be susceptible to scarlet fever, he does not need prophylactic antitoxin unless hemolytic streptococci are present in the nose or throat indicating that he may be infected. If the cultures are negative for hemolytic streptococci, the prophylactic antitoxin may be withheld, providing further contact with the scarlet fever patient can be avoided. However, when exposed persons are found to be both susceptible and infected, it is safer to give the prophylactic dose of scarlet fever antitoxin unless it is possible to make daily observations for fever, sore throat and beginning rash. If this is possible the serum may be withheld until early symptoms of scarlet fever appear, such as sore throat, general malaise, or fever, and a therapeutic dose of antitoxin administered on the appearance of the first symptom.

Diagnostic Blanching Test: Scarlet fever antitoxin is also employed in the diagnosis of doubtful rashes; 0.2 cc. of scarlet fever antitoxin is injected intradermally in the center of a large area where the rash is brightest, preferably on the abdomen or chest. The reaction is observed eighteen to twenty-four hours later. A positive reaction consists of blanching of the rash in a circular zone surrounding the central red spot where the injection was made. The reading should be made by standing several feet from the patient. The rash of German measles and other non-scarlatinal rashes are not affected by scarlet fever antitoxin.

DIPHTHERIA ANTITOXIN: Diphtheria is the disease in which it was first proven that the essential pathologic mechanism is a local production of toxin, the absorption of which results in the systemic manifestations of the disease.

The diphtheria bacillus was discovered in 1883 by Klebs, was cultivated in 1884 by Loeffler and the toxin was discovered by Roux and Yersin in 1888. By 1892 the antitoxin had been demonstrated by Behring. This work is one of the most brilliant triumphs of scientific medicine. Diphtheria without antitoxin treatment had a mortality of something like forty percent. With the antitoxin the mortality depends entirely upon the stage of the disease in which it is used.

Method of Administration: For therapeutic use diphtheria antitoxin is now given either by the intramuscular route or intravenously. Park[1] has shown that serum given intramuscularly is

absorbed three or four times as quickly as when given subcutaneously. When given intravenously it is absorbed about ten times as rapidly as when given subcutaneously. The intramuscular injection insures an absorption sufficiently rapid for any but the exceptionally severe cases. We prefer as a site for such injections the quadriceps extensor muscles at the middle of the thigh. We do not advise the intravenous use of serum without previous desensitizing methods.

Dosage—The dose of diphtheria antitoxin depends upon the following factors:

1. Toxicity of the disease as manifested by the patient's condition (pulse, temperature, etc.).
2. The day of the disease. Beginning cases need but little as compared with advanced cases.
3. The location of the lesions. An extensive involvement usually results in the production of much toxin. Nasal and laryngeal forms as a rule require more antitoxin than tonsillar forms.
4. The amount of antitoxin required will vary to some extent with the age of the patient.

The following table is modified from that of Kolmer:

	Mild cases	Moderate cases	Severe cases	Malignant cases
Infants	2,000-3,000	3,000- 5,000	5,000-10,000	10,000
Children, 30-90 lbs.	3,000-4,000	4,000-10,000	10,000-15,000	10,000-20,000
Adults	3,000-5,000	5,000-15,000	10,000-20,000	15,000-40,000

The intravenous use of one-half the amount specified in the malignant cases is advised while the remaining half is given intramuscularly.[2]

Many authorities advise the use of larger amounts.

In our own work the dosage used is approximately double that given in the table. A first dose of less than 5,000 units is never advised while initial doses of 40,000 units are frequently given.

An attempt is made to give all of the antitoxin necessary in one dose, but if marked improvement has not occurred in twelve hours the dose is repeated or twice the initial dose is given.

As to therapeutic results, Ker[4] states that he has never seen a death when antitoxin was given on the first day of the disease.

Unfortunately, even with the present wide dissemination of knowledge of the importance of early administration of antitoxin, cases are seen in which the tissues have been damaged beyond repair or in which laryngeal and tracheal swelling produce fatal results before antitoxic action is effective.

With due care to avoid anaphylactic shock serum should be given in cases suspected of diphtheria without waiting for a bacteriologic diagnosis. However, in the handling of healthy contacts the indiscriminate injection of antitoxin is to be avoided. The course to be followed is in every way comparable to that just outlined for scarlet fever contacts.

Cultures should be made in all anginas and in nasal discharges with severe constitutional symptoms so that atypical cases may receive antitoxin early.

Desensitization: It was noted by Rosenau and Anderson that guinea pigs which had recovered from anaphylactic shock were not affected by further injections of the same protein when given soon after recovery. They also found that by repeating injections at weekly intervals following the sensitizing dose, the anaphylactic state was prevented.

It has been found also that animals can be desensitized by repeated sublethal or subtoxic doses of the protein to which the animal is sensitive.

This knowledge is made use of in avoiding dangerous reactions in persons who are sensitized to horse serum either through previous administration or from horse asthma.

Unfortunately all of the curative serums in common use as well as most of the antitoxin or toxin-antitoxin mixtures for immunization against diphtheria contain horse serum. It, therefore, not infrequently happens that it is desirable to give second injections of horse serum.

The following precautions will be of service in avoiding unpleasant or dangerous reactions:

I. The use of injections of horse serum should be avoided entirely if possible.

II. It should be remembered that the intravenous and intraspinous administration of serum is more dangerous than the subcutaneous or intramuscular injection.

III. All persons in whom the use of horse serum injections are contemplated should be questioned concerning a history of—

1. Previous serum injections, including toxin-antitoxin.
2. Asthma.
3. Urticaria.

IV. If there is anything to suggest a possible hyper-sensitiveness to horse serum, desensitization may be carried out as follows: A 1-10 dilution is made by taking 1/10 cc. of serum to be used and diluting with normal salt solution to 1 cc. A Luer type syringe may be used for the dilution. Subcutaneous injections may then be made as follows every fifteen minutes:

First injection—1/4 cc. of 1-10 dilution.
Second injection—1/2 cc. of 1-10 dilution.
Third injection—0.1 cc. of undiluted serum.
Fourth injection—0.5 cc. of undiluted serum.
Fifth injection—1.0 cc. of undiluted serum.

One-half to one hour later the remainder of the necessary amount of serum may be given.

V. In those who give a history of horse asthma skin tests should be made by making a small scratch or by removing the superficial layer of skin with a Von Pirquet Scarifier in four places on the forearm, one and one-half inches apart, and applying to the denuded area dilutions of horse serum as follows:

1. 1-100
2. 1-1,000
3. 1-10,000
4. 1-100,000

A sensitized person will react within fifteen

minutes by the production of one or more urticarial wheals at the test areas. Desensitization should then be started by injection of 0.1 cc. of the dilution next higher than the highest one giving a reaction.

In addition to the specific desensitization, an injection of atropine sulphate (gr. 1/100 to an adult) may be given before the serum injection.

A solution of adrenalin hydrochloride 1-1000 should always be ready for use in case untoward symptoms develop. A dose of 1/2 cc. of such solution is sometimes given hypodermically before the serum is injected.

Serum Disease: From the time of the first use of serum, rashes were noted following their administration. Von Pirquet and Schick[3] made the first comprehensive study of the condition and originated the name serum disease or serum sickness.

The anaphylactic nature of the phenomenon is generally conceded although Coca has regarded it as belonging to the group of drug idiosyncrasies.

The symptoms develop most commonly a week or two weeks following the use of the serum, although it may occur at any time from a few hours following the use of the serum.

The most common symptom is a rash and this is usually of an urticarial variety. Sometimes it is extremely severe with extensive edema. The disease is practically always accompanied by fever which is usually low but may reach 104 degrees F.

As variations from the usual eruptions the rash may resemble measles so closely as to necessitate examination for Koplik's spots in order to make sure of its nature.

Still less frequently the exanthem may resemble scarlatina, from which it is usually differentiated by the absence of angina. This type of rash tends to occur earlier than the other two.

In addition to the exanthem and fever there are frequently joint pains, diarrhœa and rarely nausea and vomiting.

The usual procedures in the treatment of serum sickness include:

1. Administration of a saline purge.
2. Calcium lactate gr. xv to xx and sodium bicarbonate gr. xv to xx in adults with proportionate doses for children.
3. Aspirin gr. v or x q. 3 hours for itching and joint pains.
4. Adrenalin—M v to x of a 1-1,000 dil. by hypo q. 3 or 4 hours, or ephedrine .75 gr. by mouth.
5. Sometimes atropine gr. 1/100 by hypo. if adrenalin fails to help.

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MALIGNANCY IN SOFT TISSUE

REPORT OF SIX CASES

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The study of malignancy as occurring in soft tissues is entirely too vast a subject to be any more than briefly touched upon at any one time. So much has been written and yet so little learned "from whence they come or why or whence they go and when" that one is indeed humbled in the enormity of their presence and finds perhaps a crumb of comfort in the words of the ancient Persian sage,

"Myself when young did eagerly frequent
Doctor and saint and heard great argument
About it and about but evermore
Came out by the same door where in I went."

Clinically and pathologically, however, we have learned to recognize certain forms, their sites of election, their growth, method of extension, and average ultimate course and have, perhaps, with the advent of radium and x-ray, learned something more in recent years of how to combat their increasing progress. Whether one believes the applicability of Maud Slye's great work in proving the heredity of carcinoma in mice or whether he finds refuge in the theories of Conheim, Ribbert, Czerney, and others matters little at the present time, for the first and last positive words concerning malignancy are still to be written.

The classification made by Virchow in 1863[1] may still be used practically unchanged in the consideration of malignant growths; namely,

I. Tumors developing from connective tissues:
 a. The sarcoma (composed of unripe connective tissues rich in cells) with its subdivisions:
 1. Composed of cells of any of the connective tissues.
 2. Composed of cells resembling lymphoid cells.
 3. Composed of mucoid tissue-myxoma and myxo-sarcoma.
 4. Composed of pigment cells-melonoma and chromato-phoroma.

II. Tumors developing from epithelium of which is the:
 a. Carcinoma, with its subdivisions depending upon the origin of the epithelium.

III. Tumors composed of endothelium.

IV. Mixed tumors.

Of this group he also recognized histioid tumors, the structure of which resembles the structure of normal tissue;

The organoid tumors, which resemble in structure the different viscera of the body, being composed of an interstitial tissue and a parenchyma, and a

Systemadoid or teratoid tumor with a complicated organic structure resembling that of the body or a part of it.

Clinically, practically all malignant tumors have several characteristics in common; that is,

they begin by a small primary focus which infiltrates the surrounding tissue steadily and progressively, spreading by the lymphatics or by the blood stream; they produce ulceration and fungation when involving a cutaneous surface; are noncapsulated in their later stages; are almost certain to recur unless completely excised; commonly become disseminated throughout the body by means of emboli; produce severe cachexia and, unhampered in their course, cause death.

Pathologically, the basic difference among malignant tumors seems to be in the type of tissue from which they spring and of which they are composed: those of epithelial origin and growth classed as carcinomata and those from connective tissue cells in any of their varied forms as sarcomata. As there are clinically all degrees of progression of growth with metastases, so are



ANGIOSARCOMA OF GREAT TOE

there pathologically an almost infinite number of forms which they may assume which makes a definite classification at times almost impossible.

In the carcinomata, two structural units are encountered, viz., the parenchyma and the stroma. The former are composed of epithelial cells differing morphologically and in their arrangement depending upon whether they have developed from mucous membranes, skin, glandular viscera, epithelial cysts, embryonal rests or from pre-existing fibro-epithelial structures; and in spite of their ofttimes rapid proliferation, they preserve the characteristics of the parent cells.

The latter is composed of trabeculated, newly-formed, connective tissue of varying thickness and firmness which may be also partly composed of the old tissues invaded. The preponderance or absence of this connective tissue stroma is a great factor in the determination of the degree of malignancy. In the scirrhus type, such as is often seen in the mammary gland, the stroma predominates and the growth is slow with a tendency to cicitrization. In the opposite form, or medullary carcinoma, as may be seen in the stomach, the growth is rapid with a greater tendency to early metastases. An intermediate form is recognized and is known as carcinoma simplex, which predominates numerically over either of the other two.

The clinical aspects of carcinomata are, unfor-



CARCINOMA OF ORBIT (Squamous Cell Type)
(Miss E. H. B.)

tunately, all too commonplace. In general, it is known that they are rare before the age of thirty and most common after forty; that women are more liable to carcinomata than men, in a large measure owing to the frequency with which the disease attacks the uterus and breast. Cancer of the mouth and other portions of the alimentary canal is more common in men. From seven to fourteen percent seem attributable to injury or irritation to tissues involved. Thus, epitheliomata of the lip are frequently seen in pipe smokers, and adeno-carcinomata apparently developing at once after a traumatism to the breast.

Following the work of Thiersch, Waldeyer and Houser, Van Recklinghausen, in 1862, also demonstrated that certain forms of tumors previously classed as carcinomata were derived from the endothelial lining of blood vessels and lymph spaces and should be considered as constituting a separate group known as endotheliomata. This was also later emphasized by Koster[2]. Clinically, these constitute a rare but an important place among the malignancies.

Delafield and Prudden[3] state that normally endothelial cells are thin and elongated and form a sort of mosaic over the surfaces they line, but that in inflammation or malignant degeneration with hyperplasia, they often become markedly thickened, enlarged, and cuboidal in shape.



ENDOTHELIOMA OF AXILLA
(Mr. W. H. B. August 6, 1927)

In the endothelioma, such transformation does occur and the parenchymal structure of this form of tumor becomes composed of masses of bizarre forms of endothelial cells, forming often tubular structures resembling their original functional arrangement. Not infrequently the tumor mass is composed of solid endothelial reticular masses with very little connective tissue stroma. Occasionally the stroma becomes very vascular, in which event the growth resembles some of the forms of angiosarcoma.

The cholesteatomata represent a derived form of endothelial structure in which the cells are arranged and packed in dense concentric masses which have a glistening appearance. This appearance is often due to the presence of crystals of cholesterin.

Psammomata, as seen occurring in the dura, may be composed of densely packed layers of endothelial cells polyhedral or cuboidal in shape, grouped about blood vessels.

The stroma of endotheliomata may undergo various forms of alteration, developing hyaline, myxomatous, cystic, cartilaginous, or even sarcomatous degeneration in which event the growth becomes a mixed tumor. This form is usually more malignant than the simple endotheliomata.



Gross Specimen—Carcinoma of Orbit
(Miss E. H. B.)

The hyaline forms not infrequently take cylindroid cell mass arrangement and are known as cylindromata.

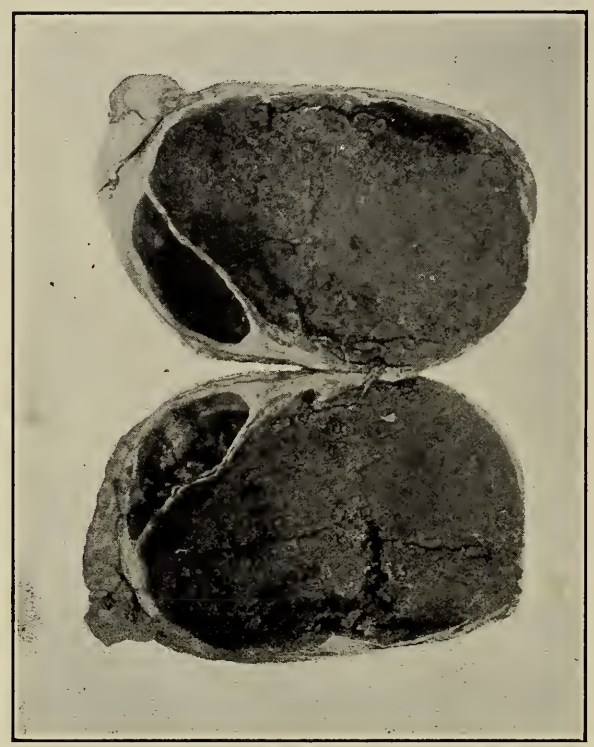
Volkmann[4], in his masterpiece, states that endotheliomata occur in the dura and pia mater, the pleura, peritoneum, skin, lymph nodes, ovary, liver, brain, testicle, carotid gland, and probably most frequently in the salivary glands.

As a class, endotheliomata are considered as much less malignant than sarcomata or carcinomata to which they often have a very close resemblance. Ernst states that there are also two types with reference to deep x-ray therapy, one highly resistant and the other quite amenable.

The following case report is illustrative:

Mr. M. W. B., a farmer, age sixty-three, presented himself for examination August 16, 1927. His chief complaint consisted of a large, rapidly growing tumor mass in the left axilla, which he stated, began as a small nodule, being discovered by him accidentally in March of that year. It was not painful up until about one month ago, and has not been accompanied by any appreciable loss of weight, dyspnœa, cough, fever, or cachexia. He recalls striking himself in the left axilla many times with a shovel handle while engaged in loading gravel during the preceding months.

The familial history is essentially negative: wife living and well—no children—no history of cancer or tuberculosis in family of which he is cognizant.



Sectioned Specimen—Carcinoma of Orbit
(Miss E. H. B.)

Personal history was likewise negative except the presence of the tumor and persistent pain in the left shoulder and arm.

The physical examination disclosed a white male, weight 166 pounds, height five feet ten inches, apparently in good condition, whose essential findings consisted of a nodular, firm, nonfluctuant about the size of a large grapefruit in the left axilla. The tumor was fixed to the underlying tissue, was only slightly tender and caused pain in the left armpit and left arm when manipulated. The overlying skin was pale and not eroded but was traversed by numerous large veins. There were no enlarged regional glands palpable. Other examinations, including Kahn and Wassermann reactions, were negative. Hemoglobin showed eighty percent with normal relations of white cells. X-ray of the chest and long bones did not disclose any evidence of metastases.

With the belief that the tumor was malignant, he was given two exposures of deep x-rays of fifteen minutes each, six days apart, using 180,000 KV at fifty centimeters distance, five mill. amp. through a one-half copper and one-half aluminum filter.

On August 24th the tumor was excised. It was found to be infiltrating the pectorals, which were removed to the costal surfaces. These seemed clear. The axillary structures were dissected free, and in this area the growth seemed to me to be encapsulated. The tumor itself, when removed, was about the size of a football, was grayish pink in color, very friable, and not unusually vascular. It had not invaded the skin, and had not undergone any appreciable necrosis in the central area. A gutta-percha drain was placed in the axilla after closure of the wound and on the twenty-seventh of August the x-ray treatment was repeated. The wound healed readily with very little



Figure 1. Photomicrograph of squamous cell carcinoma of orbit. (Hemalum and eosin stain. Zeiss objective "B." No ocular. Bellow's length 130 cm.) Medullary masses of atypical squamous epithelium showing cornification are found growing into new-formed connective tissue. There is a marked mononuclear infiltration about the masses of carcinoma cells.

drainage and on September second and sixth he was again given x-rays as before. He left the hospital September 6, 1927.

To date, he has been free from pain, has been following his work without inconvenience, and presents no clinical evidence of return of the tumor. Whether or not it will return is, of course, at this time problematical.

The microscopic examination as given by the University of Michigan showed that the growth, instead of being a sarcoma as we believed it to be clinically, was a perivascular endothelioma of almost pure type.

Of the many forms that carcinoma may assume, perhaps one of the most commonly seen is the epithelioma or squamous cell type. These occur frequently in the skin, especially at the mucocutaneous junction such as the eyelids, nares externa, mouth, cervix uteri, vagina, and æsophagus. They

may also rarely develop in congenital nævi of the skin.

The cells forming this type of carcinoma present all the various forms normally existing in the skin, and in addition, due to the older tumor cells becoming densely packed in concentric masses by the rapidly growing young cancer cells, numerous whitish lamellated structures known as epithelial pearls. These epithelial pearls are not confined to these tumors but their presence in a malignant tumor of questionable origin is almost diagnostic.

Clinically the growth is frequently looked upon as a malignant wart which not only grows outward from the surface and ulcerates, but infiltrates deeply the surrounding tissue and adjacent lymphatic structures as well as producing visceral metastases. While the primary focus is often



Figure 2. Photomicrograph of squamous cell carcinoma of orbit. (Hemalum and eosin stain. Zeiss objective "B." No ocular. Bellow's length 130 cm.) An area of infiltrating carcinoma cells, showing the marked cornification exhibited by this neoplasm. Large masses of laminated keratohyalin are found in the lower half of the field.

small, and about the face assumes the form of an ulcerated, non-healing ulcer, it may become large, hard, nodular and assume an almost pedunculated form with no superficial evidence of erosion. This is rarely encountered and the following case is presented on this account:

Miss E. B., age forty-six, a native of a small town in central Indiana, was admitted to the Lutheran Hospital June 17, 1924, complaining essentially of a large growth springing from the left orbit.

The family history revealed that one brother, at the time of his accidental death, had numerous tumors over his body, which condition was diagnosed by physicians as Von Recklinghausen's disease. That her mother had a tumor removed from her face without recurrence; that one sister had a growth excised from her elbow; that one brother died at the age of thirty of what physicians termed as internal cancer, and that the grandparents of the patient were first cousins.

Her past history was essentially negative except with reference to the tumor mass. This briefly was that at the age of five an enlargement of the left eyeball was noted. This was preceded and accompanied by intense aching pain in this region. The eyeball continued to enlarge and protrude and after about one year of suffering, the eyeball spontaneously ruptured with the escape of a considerable quantity of brownish fluid of a thick, syrupy consistency. The eyeball diminished somewhat in size, but continued to slough, and with exacerbations and remissions of pain for about five years, it finally slowly healed with a smooth scar and only slight bulging. No sight was present and apparently the eye structure was totally destroyed.

As the patient continued to develop into maturity, the tumor mass gradually increased in size until her full stature and permanent weight were established. At this time the tumor had

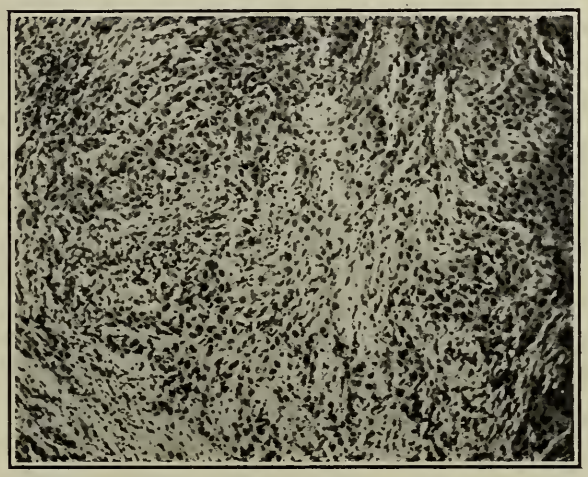


Figure 3. Photomicrograph of squamous cell carcinoma of orbit. (Hemalum and eosin stain. Zeiss objective "B." No ocular. Bellow's length 100 cm.) This illustrates an area in which the carcinoma cells grow in a diffusely infiltrating manner through a new-formed inflammatory stroma. In these younger, less differentiated, areas cornification is not taking place.

reached its present size and caused her little annoyance except that within the past three months it has become at times painful within its base. She also noted that headaches were slightly more frequent during this interim but at no time were they severe. Three years ago she noted the rapid appearance of many small skin tumors covering almost her entire body but showing a special predilection for the forearms and extensor surfaces. These have not disappeared to date and cause only cosmetic annoyance.

The physical examination disclosed an adult white female, ambulatory and apparently in fair health, who presents essentially a very large tumor mass originating from the left orbit, beneath the projecting shelf of bone (a prolongation of the left supraorbital process). The tumor mass is firm, somewhat nodular, and covered by cuticular tissue resembling an immensely elongated upper eyelid. The palpebral fissure is absent and no sloughing areas are noted. The tumor is about the size of a football, and mechanically protruding, has destroyed the entire facial contour,

pushing the nose to the right and distorting the mouth. The right eye is apparently normal.

Other examinations were negative except for the presence of many small, firm, painless, nodular tumors from the size of a pinhead to a split pea within the skin. These were most numerous over the extensor surfaces, the forearms and abdomen. The blood Wassermann was negative and the relative proportion of corpuscles about normal. Systolic blood pressure was 110 and diastolic pressure was eighty.

At operation, a few days following admission, the tumor was readily dissected free and was found to extend deeply into the left orbital fossa. The base was very vascular and the hemorrhage controlled by gauze packing. A large portion of the projecting orbital plate was removed and the wound closed by approximation of skin flaps. Drainage was provided for by means of gauze wicks.

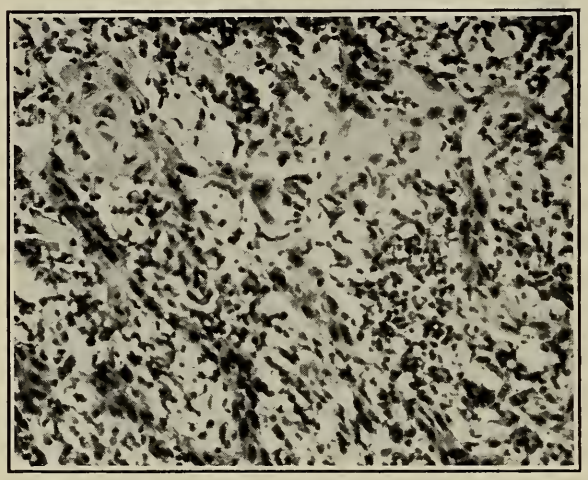


Figure 4. Photomicrograph of squamous cell carcinoma of orbit. (Hemalum and eosin stain. Zeiss objective "DD." No ocular. Bellow's length 130 cm.) This higher power photomicrograph shows an area in which the carcinoma cells are infiltrating in the form of long strands and columnar masses among the fibers of the orbital muscle. The surviving voluntary muscle fibers are best seen in the upper half of the field. They are cut in cross-section and can be recognized by their larger size, peripherally-placed nuclei, and cytoplasm which photographs in a light gray tone, distinctly lighter than that of the carcinoma cells and darker than the background.

The patient withstood the shock of the surgical procedures seemingly very well, regaining consciousness and presenting no apparent untoward symptoms for the first twenty-four hours except a persistent thin bloody serous drainage. The following twenty-four hours she sank into coma, and death ensued. The pulse rate and blood pressure remained almost normal until about two hours before her death, at which time it showed marked regression.

Clinically, the tumor mass was believed to be a sarcoma. It was definitely encapsulated, and the medullary portion was rather soft near the center, friable, pink to grayish white in color, and fairly vascular.

Pathologically, it was diagnosed by the University of Michigan as a squamous cell carcinoma, and in evidence of this view pointed out by means of microphotographs, areas of infiltrating carcinoma cells with cornification, and laminated keratohyalin, within new-formed connective tissue. Also within the stroma many medullary masses of atypical squamous epithelium showing cornification. The skin tumors were fibromata.

No autopsy was permitted, hence it is not known whether there were metastases present elsewhere, but symptomatically, if they did exist, they gave no sign.

Another type of new growth encountered in soft tissue that may clinically be indistinguishable from carcinoma is the lymphangioma.

The ordinary lymphangiomata are benign and consist of dilated lymph channels which either preserve approximately the general shape of the original channels, or become cavernous or, less commonly, cystic. According to Delafield and Prudden[5] they probably originate in part in newly formed and in part in old lymph channels. The dilated channels are usually filled with a translucent or milky fluid.

The tumors themselves may be congenital or acquired and when found in the skin, they are soft and slightly elevated growths. Occasionally undergoing malignant degeneration, they may clinically assume the characteristics of adeno-carcinoma as is illustrated by the following case:

Mrs. McK., white, age thirty-seven, a native of Indiana, was brought to the hospital March 28, 1925, complaining at the time of admission of violent, recurrent, cramp-like, generalized abdominal pain, fecal vomiting, distention of the belly, and prostration. These symptoms of acute bowel obstruction had been present for about eighteen hours and had suddenly climaxed a syndrome of dull aching pain in lower abdomen, chronic constipation, progressive loss of weight, general malaise, and weakness, which had an insidious onset and had been noted by the patient for about six months.

Her family history was negative. The personal was likewise, except for a laparotomy ten years preceding for appendicitis. At this time a small cystic right ovary was also removed. Six years later a second laparotomy was performed, this time for adhesions. Following both operations she made uneventful recovery and until the past six or seven months had felt well and had followed her avocation of a housewife.

As the symptoms of obstruction did not subside, a laparotomy was performed, primarily for the purpose of effecting relief from this condition. A part of the report from the operative record is as follows:

"Incision of abdomen parallel to old mid-line scar, which is excised. Dense masses of adhesions are encountered between the omentum, small bowel and abdominal wall. Bowel dissected free from adhesions and omentum and obstruction located in ileum due to a dense fibrous band causing torsion and kink. This is relieved by section of band. Masses of friable whitish-pink tissue are seen.

almost filling the already large omentum and mesentery. These are from the size of a pinhead to that of a dollar, are elevated, firm, and lend the impression that a piece of the omentum could easily be broken off. The mesenteric glands were also enlarged, firm, and nodular."

At the time nothing more was done except the relief of the obstruction and the removal of some small portions of the growth for microscopic examination. It looked like a typical generalized carcinomatosis and a hopeless ultimate prognosis was given. Much to our surprise she made an uneventful recovery and upon discharge from the hospital on April twenty-second was subjected to heavy divided doses of deep x-ray. This was repeated again in June of that year.

She continued to improve, the swelling and doughy feel of the belly disappeared, the weight increased to normal and apparently after about six months she had regained her former health. She was treated at various times later for a rather persistent genito-urinary infection, but otherwise no untoward symptoms were manifested.

In August, 1927, she was again given a small dose of deep x-ray following which she was very much weakened and nauseated. She has been seen and examined about every three months since her operation and thus far has maintained her weight and enjoys apparent good health and shows no clinical evidence of recurrence of the growth or metastases elsewhere.

The pathological report of the sections as given by the University of Michigan showed cystic lymphangioma of the omentum with varying degrees of malignant degeneration.

It would seem that such a case was definitely influenced for the better, if not cured, by the x-ray, and while its failures in the vast majority of abdominal malignancies predominate, an occasional result like this justifies its use.

The approved treatment of lymphangioma is surgical excision and in the large, cavernous, nonmalignant type as may be encountered in the neck, excision with packing of the cavity with gauze to facilitate granulation is usually effective. Cauterization of the small types as seen in the skin will, according to Rose and Carless[6], cause disappearance without recurrence.

Regarding the sarcomata of soft tissue, their causation, course and treatment, even less is known than of the carcinomata.

Pathologically, in general, they are formed of cells resembling developing embryonal connective tissue or the granulation tissue of inflammation. The usual predominating element in sarcomata is the embryonal type cell and these may be spheroidal, flat, fusiform, cuboidal, cylindrical or even branched with all gradations in size from the small round cell type to the large multinuclear variety. The amount of connective tissue stroma, or fibrillar basement substance, may also vary from almost a total absence to a preponderance in proportion to the medullary portion of the growth. However, the embryonic sarcoma cells always stand in a close relationship to the basement substance even though the gross arrangement may be almost alveolar in type.

Blood vessels are also more constant in the growth and development of sarcomata than in carcinomata and occasionally in the former they would seem to constitute the most important element in determining the structural outline and growth.

It is notable that in the sarcomata each parenchymal cell is separated from its fellow by delicate fibrillæ while in the carcinomata these cells are grouped in masses or alveoli and are either enclosed or distinctly marked off from the stroma.

There is usually a tendency in these tumors to reproduce some of the special characteristics of the tissues in which they may originate.

Owing to their marked vascularity, metastasis is more apt to occur through the blood than through the lymph channels and the regional lymph nodes are less prone to be involved in developing sarcomata than in a carcinoma. Occasionally, however, dissemination by way of the lymph channels takes place. This is seen especially in the melanotic sarcoma of the skin, sarcoma of the testis, tonsil, thyroid and the various forms of lymphosarcoma.

Two types of cells are most commonly found in sarcoma, namely, the spindle cell and the round cell, so designated from their respective shapes.

In the former there are two subdivisions, the large spindle cell and the small one. Both of these types of cells are usually arranged in fasicles surrounding or interlacing the blood vessels.

The small spindle cell forms are not as a rule as malignant as the large, and perhaps are more often encapsulated. They are found most often in the periosteum, subcutaneous tissue, and in various glands, notably in the testicle, thyroid, and mammary glands. These forms are among the most common of sarcomata.

The round cell sarcoma is subdivided into two classes also from the size of the parenchymal cells. Of these, the small round cell type is the most to be feared as their growth is very rapid and their early metastatic tendency is marked.

In this type the parenchymal cells are small and round, deep staining, and resemble small mononuclear leucocytes. There is not often much intercellular stroma. The vascularity is very marked and ulceration with hemorrhage usually severe. They occur most frequently in connective tissue of muscles and fascia, in bone, and in lymph nodes. In this last type they are often designated as lymphosarcoma. Occasionally they are found in the brain in conjunction with gliomata.

In the large round cell sarcoma, the cells, while varying in shape, are usually much larger in size than the small type which they resemble. Their nuclei and nucleoli are usually very distinct.

While they may be very vascular, they are seldom as malignant as the small round cell type and clinically firmer and more often encapsulated.

One of the most highly malignant of the sarcoma group is that designated as melano-sarcoma. These consist usually of polyhedral cells of various sizes which contain particles of brown or black pigment. The origin of this pigment, known as melanin, is still in doubt, but due to the fact that it does not contain iron, seems to indicate that it is not derived from the hemoglobin.[7] It is usually irregularly distributed in streaks or patches and sometimes occurs, not only within the parenchymal cells, but in the intercellular framework.

Clinically, they arise within the skin often from an irritated pigmented mole, or in the choroid. They form secondary deposits in the adjacent lymph nodes and in the viscera very rapidly, often within a few weeks, and quickly prove fatal. Once developed, they are also very resistant to x-ray and other forms of therapy.

The following case is illustrative:

Mr. W. H. B., a white adult, age sixty-one, a native of a rural district near Fort Wayne, was seen September 17, 1923. He presented a black, elevated, papillomatous area about the size of a dollar on the outer aspect of the left thigh.

This mole, as he termed it, had been present since birth and caused him no annoyance until about five years ago, when it began to enlarge slowly. In the beginning it was about the size of a dime and the growth has been painless. The slight superficial elevation has developed within the past month. His family and personal history were negative. His weight of two hundred ten pounds has remained fairly constant.

The physical examination was negative except as given. X-rays of the chest did not disclose any metastatic shadows.

A diagnosis of melanotic sarcoma was made and a wide, deep excision of the growth was performed. He withstood the removal well and left the hospital the next day. The wound healed by primary union and apparently a recovery seemed imminent.

Two months later, November 19, 1923, he again presented himself and at this time a small black fungating area about the size of a pea was visible in the central portion of the scar. It was slightly moist and not painful. He stated that the growth had been noticed by him about two weeks. No regional glands were palpably enlarged.

The removal this time was very wide and deep, extending several inches beyond the scar and into the muscles. The wound healed by primary union, but within two weeks he complained of weakness, dyspnœa and cough. The x-ray showed the lungs completely riddled with small metastatic growths. His death ensued within less than six weeks from the date of the secondary operation.

It would seem that if anything is to be done surgically with an active melanotic growth, it should be practiced very early and consist of a very wide and deep excision with the white hot cautery.

The myeloid, or giant cell sarcoma, while usually seen in connection with bony structures, may originate in the marrow of peri-osseous tissues. Certain forms of epulis, as encountered in the mouth, are giant cell sarcomata.

The diagnostic sarcoma cell is, in this type, one of many deep staining nuclei. They are often spheroidal or fusiform, and closely intermingled with the smaller parenchymal cells, but are generally much larger.

This type of tumor also forms metastases readily after it breaks through its common restraining capsule, but it not infrequently reaches very large size before this happens.

A rather rare type of sarcoma which is highly malignant is known as the alveolar sarcoma, in which the parenchymal cells take on almost the characteristic form of carcinomatous arrangement. In this type the cells, while in trabeculated spaces, as in the carcinomata, still maintain an integral relationship to the stroma in the areas of contact and are not lying loosely. Their resemblance to the endothelioma is very close. They occur in the skin, lymph nodes, bones, and pia mater.

The mixed forms of sarcoma are quite common. They are so named generally as a result either of the characteristic degenerative processes or the type of tissue cell that the embryonic sarcoma cell resembles.

Combinations of sarcoma and fat tissue develop the terminology often of liposarcoma. Similarly, with glandular structures the adenosarcoma is encountered as is also the chondrosarcoma in relation to cartilage. With muscle tissue, the myosarcoma may be named. Mucous degeneration is frequent in the various forms of sarcoma and the combination of myxoma to sarcoma is quite common. Psammoma, or brain sand, sometimes found within the dura, are often sarcomata in early stages. Chloroma, or the small round cell, sarcomatous growths, found usually in bone primarily, but secondarily in the soft tissues, are very rare and are characterized by a greenish color the nature of which, like melanin, is still undetermined.

The angiosarcoma, while not as common as some of the other varieties, is often seen. This form of malignancy, like the other sarcomata, is more apt to occur in early life, affecting especially the first and fourth decades.

It is characterized pathologically by the peculiar arrangement of the sarcoma parenchymal cells which are densely packed about the many blood vessels within and aiding the formation of the tumor. These cells are firmly attached to and often form the bulk of the adventitia of the blood vessels, which thus form a central canal for each group. The cell masses may be arranged in somewhat globular or alveolar shapes or, what is more common, in long strings with frequent anastamoses.

Clinically, it is prone to early metastases, develops usually primarily in soft tissues and is regarded as among those of very malignant form, especially if involving surgically inaccessible structures. While often seen within visceral cavities, it may occur externally. The following cases are illustrative of each location:

C. S., a youth of ten years, was admitted to the hospital October 1, 1927. His chief complaint consisted of a slow growing tumor arising under the nail of the right great toe. It was only slightly painful and had started from a bruise on the top of the toe four months before. The growth had persisted despite local medication and upon admission was about the size of a large walnut.

The tumor was firm, somewhat fungous on the surface, very vascular, reddish in color and resembled a large, heaped up, encapsulated mass of granulation tissue. The nail was displaced upward. No regional glands were palpably enlarged. Other examination was essentially negative.

At operation it was thought that the growth was malignant and a wide excision of the top of the toe including the distal phalanx was done by means of the white-hot cautery.

The wound healed slowly by granulation and thus far no evidence of recurrence has been noted.

The pathological examination disclosed an angiosarcoma. This variety is supposedly more amenable to x-ray than some of the others, especially the bone sarcomata.

In the visceral location, Mr. R. C. offers a tragic example.

A young traveling salesman, age twenty-three, native of Indiana, was admitted to the hospital on February 11, 1926. His chief complaint consisted of pain in the rectum, a sense of weight in the right side of the pelvis with pain in the right thigh, knee and leg, and the development of a small painful tumor mass in the perineal region.

The onset was rather abrupt, dating eight weeks before, with pain in the perineum and constipation, chilly sensations, afternoon fever, nausea, general malaise, and loss of weight. During this time he had lost about twelve pounds. At first the pain in the lower pelvis and perineum was paroxysmal, but since the development of the bulging at the side of the rectum, it has become constant and interferes with his sleep. The first three weeks of his illness was so severe that he was bedfast, but since that time he had become ambulatory.

The family and personal history were negative. Blood examination showed a negative Kahn and Wassermann reaction, a slight relative leucocytosis and anemia. Urine was negative.

Physically, he was fairly well developed, weighing one hundred and forty-eight pounds. The chest showed nothing abnormal; abdomen not distended or tender except slightly on deep pressure within the pelvis.

His essential findings consisted of a painful, tender, fluctuant, swollen, reddened mass about the size of a grapefruit in the perineum bulging somewhat to the right of the anal orifice. Clinically, it was considered as an acute ischio-rectal abscess and he was prepared for surgery, the intention being to incise and drain it.

Nitrous oxide anesthesia was induced and, with the patient in a lithotomy position, a curved incision was made through the skin over the bulging mass. A finger was introduced into the mass and a cavity about the size of a large orange was encountered. This was partially filled with a soft, pinkish, gelatinous tissue about the consistency of coagulated egg white, which came away freely. The removal was followed by a profuse bleeding which was only checked by packing in over two yards of folded four-inch gauze. After the hemorrhage had been thus controlled, no other operative measures were instituted, and he was placed in bed.

The tissue fragments removed were collected and sent to the pathological department of the University of Michigan, from which the following report was received:

"The tissue has the consistency of liver with much clotted blood mixed in with the organized tissue.

"Microscopic: The sections show typical areas of both round and spindle cells. Throughout, there are many large blood spaces, some showing beginning obliteration. There is considerable perivascular infiltration.

"Diagnosis: Mixed cell angiosarcoma."

The patient reacted fairly well from his surgical experience and the gauze pack was fearfully removed—a small portion at a time for several days without exciting another hemorrhage.

The wound slowly closed except for a sinus about the size of a lead pencil and, generally, he seemed somewhat improved. However, the pain was more severe in the pelvis and right thigh and required occasional doses of morphine. He was taken home March 3, 1926, and continued to decline, losing weight progressively, bleeding at times violently from the rectum and from the sinus, which never closed. The pain in the lower abdomen, right hip and knee became constant, and more severe, requiring larger doses of morphine to relieve him and on June 16, 1926, a merciful death intervened.

The autopsy report from the family physician reads as follows:

"Upon opening the abdomen, a mass about the size of a croquet ball was found in front of the bladder, the latter was pushed up and free on the back wall even to the cul-de-sac. The entire lower pelvis was filled with jelly-like matter of blood clots and brain-appearing tissue within a sac. The intestines were free and showed no metastatic growths. The original perineal opening was present and a mass of this tissue was pushed out to the size of a fist. The mass was almost

wholly on the right side and into the obturator foramen with nerves and blood vessels running through it. A hole was present in the bladder near the right ureter, about the size of a nickel, and about four ounces of bloody urine was in the bladder. The prostate seemed uninvolved." No report was made of metastases in other viscera, but it is not unlikely that they did exist.

In closing, a word regarding treatment of malignancies may not be amiss. It would seem that while we are still facing tremendous odds in this great problem, it is not hopeless. It was a dictum of our forefathers in the medical field that early recognition of malignancy and wide excision offered the best ray of hope, and apparently it still stands, aided and supported by the recent valuable adjunct of the x-ray and radium before and after the surgical procedures be instituted. Perhaps in the millennium to come we may live to see this scourge of mankind controlled by other means.

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NOTES ON THE HISTORY OF THE INDIANAPOLIS MEDICAL SOCIETY AND ITS INFLUENCE UPON MEDICAL EDUCATION

H. G. Hamer, M.D.
INDIANAPOLIS

I wish to tender grateful acknowledgement to the members of the Indianapolis Medical Society for the honor of serving as its president during the past year, and I hope some progress has been made in the work of the organization. I am glad to say that I believe the medical profession of Indianapolis in all its history has never been more harmonious than at present.

Forty-two papers were read by members of the society during the past year. These papers were seriously presented and interestingly discussed, and of scientific value. The papers and discussions were a valuable contribution to the work of our society. We have been honored by having as our guests eleven out-of-town speakers, among whom were eminent men of the profession. The increased average attendance is an encouraging indication of wholesome interest in the society's work.

The past year has drawn heavily upon our membership in the deaths of Dr. L. C. Cline, Dr. W. H. Foreman, Dr. Paul F. Robinson, Dr. O. G. Pfaff and Dr. John H. Oliver. These men were prominently active in the affairs of the Indianapolis Medical Society over a long period of years and had much to do with its development. Their lives and work constitute a very real part of the society's history.

The Legal Association, the Ministerial Association and other professional associations of our community have memorial meetings immediately following the death of a member. A fraternal organization may hold a "lodge of sorrow" once a year, but it is hardly in keeping with the respect we owe these men to hold a memorial meeting *en bloc*. Until quite recently it was the custom of this society to hold a memorial meeting immediately after the death of a member and a return to the older custom would seem desirable.

In thinking along this line it occurred to me that it would be of interest to present some matters concerning the early history of the society, its development, its progress and its influence.

Upon investigation I find that a state medical society existed in Indiana over one hundred years ago. This society was disbanded in 1825. Dr. Samuel Mitchell was its president that year. Of the early doctors of Indianapolis, Dr. W. H. Wishard[1] in a paper read before this society in 1892, records the following: "Dr. Mitchell was the first resident physician of Indianapolis. He came here in 1821 and located in a log house at the corner of Washington Street and Tennessee Street, now known as Capitol Avenue, the present site of the Lorraine Hotel. Later he built a frame house sixteen by eighteen feet with a shed room in the rear, located on the northwest corner of Meridian and Washington Streets, where he lived and kept his office. The doctor as described was a large and corpulent man. His abdomen was so large that he seldom rode his horse faster than a walk. During the Black Hawk War in 1832, five companies of mounted riflemen mobilized in Indianapolis and Dr. Mitchell was appointed surgeon. To enable him to get about faster on horseback he went to a harness maker and had a leather belt made reaching from the sternum to the pubes. He would put on his hunting shirt, then his leather belt, and mounted upon his large bay horse he was able to get about camp on the double quick.

"Dr. Mitchell was a licensed practitioner, but had never attended a course of lectures. Later in the year in which Dr. Mitchell arrived four other physicians came to Indianapolis. They were Dr. Isaac Coe, who located on Fall Creek near the present site of the City Hospital, and later removed to the present site of the Columbia Club; Dr. Livingston Dunlap, who became the partner of Dr. Mitchell; Dr. S. C. Scudder and Dr. Jonathan Cool. Dr. Cool was the only one of these who was a graduate of a medical school at the time he established himself here."

The population of the town at that time (1821-22) was about five hundred.[2] There was no post office, the nearest one being at Connersville. The first newspaper, the *Gazette*, appeared about this

*Presidential address, read before the Indianapolis Medical Society, January 3, 1928.

time. It was issued every two weeks, or whenever enough news was collected to fill an issue.

In the year 1821 there occurred an epidemic, a description of which was published in the Indianapolis *Gazette* on March 16, 1822, by Dr. Mitchell.[3] The epidemic was of so-called intermittent and remittent fever. He mentioned that out of one thousand souls in the town, on the donation and the farms surrounding the town, at least nine hundred sickened from the prevailing epidemic. There were twenty-five deaths.

The first session of the General Assembly, after Indiana was taken into the Union in December, 1816, passed a law regulating the practice of medicine.[4] The law was entitled an "Act to Regulate the Practice of Physic and Surgery."

It had for its object the organization of the medical profession into boards of supervisors in each judicial district, to meet at stated times to license such persons who, after examination, seemed qualified to practice medicine, and to fix a rate or scale of charges for medical services. The law was such that the physician not having a license could not collect his bills. As mentioned above, a state medical association existed previous to the present organization but disbanded in 1825. This state society was composed of delegates from the district medical societies, the first being organized in Vincennes in 1817. The first state medical society meeting was held at Corydon, then the state capital, in 1820. The last meeting of this society was held in Indianapolis in 1825, the seat of government having been moved thither in 1824, and was presided over by Dr. Samuel G. Mitchell. It was the last ever held prior to the organization of the present State Medical Association in 1849.

In 1825 the law was amended granting charters to state and local societies. In 1830 several amendments were made to the law. At a subsequent meeting of the legislature there was a repeal of all laws regulating the practice of medicine.

Previous to 1817 there was not a medical college west of the Allegheny Mountains; yet at that day there were eminent physicians and surgeons in the west, many of national reputation, such as Dr. Ephraim McDowell of Danville, Kentucky, the first ovariotomist, and Dr. Benjamin Dudley of Lexington, Kentucky, an outstanding general surgeon also specially known as a lithotomist.

The students of that day selected for their preceptors the best physicians in the country and prosecuted private dissections. Many of the most successful practitioners had never seen a medical college. After the laws regulating the practice of medicine were repealed a variety of men and talent embarked in the profession of the healing art. In the early thirties Samuel Thompson of Massachusetts published a work on medicine entitled "Right to Practice," price $10.00. This was the only textbook known among the Thompsonians. Dr. William H. Wishard[5] says: "I knew a stone mason who threw aside his trowel and entered the practice. A blacksmith of my acquaintance laid down his hammer and wrote to his friends that he had purchased Thompson's book and had entered the practice of medicine. Many of the midwives extended their field of activities in obstetrics to general practice. There were a few medical societies in the different parts of the state but many of the leading physicians had no desire for state organization. Indianapolis had a medical society in 1848 composed of the leading physicians of the place and its members sent out a call in May, 1849, to their professional friends to meet June 6, 1849, at ten a. m. in this city, at which time the present Indiana State Medical Society was organized. Dr. Livingston Dunlap was its first president."

From the "Transactions of the Indiana State Medical Association" for 1874 the following information is obtained, the same recorded by Dr. Thad. M. Stevens:[6] "In 1848 the physicians of Indianapolis organized what was called the Indianapolis Medical Society, the first local medical organization in this city. We do not know all who formed the membership. Drs. Sanders, Mears, Bobbs, P. H. Jameson, Dunlap, Gall, Bullard, Parry, Gaston and Andrews Hunt were among the first. Afterwards Drs. Woodburn, Thompson, Funkhouser, and others were added. Various physicians throughout the county of Marion also belonged."

This society had as its officers Dr. Sanders, president; Dr. L. Dunlap, vice-president; Dr. Bullard, corresponding secretary; Dr. Bobbs, recording secretary; and Dr. Mothershead, treasurer. The censors were Drs. G. W. Mears, Charles Parry and Livingston Dunlap. Dr. George W. Mears was the second president. This is the society that issued the call for a state medical convention in 1849. These gentlemen met once a week, at first, in the old "Governor's Mansion" that then occupied the "Governor's Circle" at the intersection of Market and Meridian Streets, a house long remembered by the "old inhabitants." As expressed by Dr. Thad. Stevens, "There in the little north room below, opening out upon the wide hall, the spirit of Esculapius often came, now to soothe the spirit wounded by home thrusts of a brother, now to fire with zeal to science and medicine, and urge to forensic combat."

This society gradually died out, disintegrated by causes hard to analyze. In 1855-56 another organization was formed. Dr. Sanders was no longer among them, having gone to his fathers. All the other old members with numerous new ones constituted the new society. Like the first society it had a regular constitution and by-laws, with appropriate officers, meeting at the different offices of the members, and reading with discussion of papers, was the order.

Drs. Kitchen, Newcomer, Parvin, Clay Brown, Darrach and Stevens were among the new members.

"From 1859 to 1863 (during the Civil War)

chaos reigned, and it was not until a later date that any local reorganization was attempted. Then a few physicians met under the name of the Indianapolis Medical Association, the first president being Dr. Athon, the second Dr. Gaston, and the third Dr. Harvey. During the latter's reign in 1864, a second organization was formed, composed partly of members of the last named society and partly of non-members. This assumed the name of the 'Marion County Medical Society.' Immediately upon its organization a union was effected between the two societies, the joint organization taking the name of the 'Indianapolis Academy of Medicine.' Dr. T. B. Harvey, as we have said, was the first president of this new society."

The Indianapolis Academy of Medicine continued as the regularly recognized local society, representing the county in the House of Delegates of the State Society until 1875. In the fall of 1874, owing to the organization of a new medical college (The College of Physicians and Surgeons) a division of the profession occurred and as a result the Marion County Medical Society was revived, the membership of which was the group which supported the Indiana Medical College, and those supporting the Academy of Medicine were of the College of Physicians and Surgeons. In 1875 the Indianapolis Academy of Medicine and the Marion County Medical Society both elected delegates to the State Society which met in May. Neither delegation was recognized and Marion County was not represented.[7] On June 9, 1875, the two societies united under the name of the Marion County Medical Society.

I am indebted to Dr. W. N. Wishard[8] for the following account of the proceedings connected with the union of the two societies at which meeting he was present: "The union meeting was held in Bradshaw's Music Hall over Bradshaw's music store, then located near the present site of Stewart's book store, 44 East Washington street. Dr. Woodburn as president of the Marion County Medical Society, presided. Dr. G. V. Woolen acted as secretary, being the secretary of the Indianapolis Academy of Medicine. The name 'Marion County Medical Society' was adopted. Dr. Mapes of Lawrence was elected president at this meeting. On November 18, 1902, the name was changed to read 'The Indianapolis Medical Society; the Medical Society of Marion County'."

Dr. W. H. Wishard, in a paper read before the State Society in 1889, says:[9] "From the best statistics I can obtain not ten percent of the physicians of Indiana were graduates of medicine in 1825, and not to exceed twenty-five or thirty percent had ever attended one course of lectures.

"Prior to 1817[10] there was not a medical college west of the Allegheny Mountains and but one medical journal in the United States, *The Medical Repository,* published at Philadelphia, then the medical Mecca of America."

In the fall of 1849 the Central Medical College,[11] located at Indianapolis, held its opening exercises. The school was the medical department of Asbury (now Depauw) University of Greencastle, Indiana. The professors who were elected to various chairs were Dr. John S. Bobbs, Indianapolis, anatomy; Dr. Baker, Cincinnati, surgery; Dr. Livingston Dunlap, Indianapolis, theory and practice; Dr. Charles G. Downey, Greencastle, chemistry; Dr. James Harrison, Indianapolis, materia medica and therapeutics; and the following year, Professor Baker having resigned, Dr. Bobbs became professor of surgery and Dr. Meeker was elected to the chair of anatomy and Dr. Deming professor of medicine and pathology. The last session of the school was held in 1851-52. From that time until the fall of 1869 there was no medical school in Indiana.

In the spring of 1869 the Academy of Medicine took steps to organize a medical school, namely, the Indiana Medical College. A committee was appointed which organized the various departments and selected members to fill the same. The academy adopted the report of this committee. The following were the gentlemen selected to fill the different chairs: J. S. Bobbs, M.D., principles of surgery; J. A. Comingore, M.D., orthopedic surgery and surgical pathology; R. N. Todd, M.D., practice of medicine; T. B. Harvey, M.D., diseases of women and children; W. B. Fletcher, M. D., physiology; R. T. Brown, chemistry; Dugan Clark, M.D., materia medica; G. W. Mears, M.D., obstetrics; L. D. Waterman, M.D., anatomy.

Dr. Bobbs died in 1870 and in the same summer Dr. Comingore was elected to the chair of surgery, a consolidation of his former chair and that left vacant by the death of Dr. Bobbs. Dr. T. M. Stevens was elected to the chair of toxicology and analytic chemistry.

In 1871, by mutual agreement, the school became a branch of the State University, having the control of its internal affairs vested in its own faculty in Indianapolis. This nominal relationship existed for but a few years.

The College of Physicians and Surgeons was organized in 1874, having had its inception in the spring of the same year. R. E. Haughton, R. N. Todd and Thad. M. Stevens having left the faculty of the Indiana Medical College, certain physicians in Indianapolis and elsewhere decided to establish a new college having a board of trustees outside of the faculty.

The board, consisting of twenty-seven members, met and selected the following faculty: D. W. Yandell, M.D., Louisville, Kentucky, principles and practice of surgery; R. E. Haughton, M.D., Richmond, Indiana, materia medica and therapeutics; J. E. Link, M.D., Terre Haute, Indiana, anatomy; Theophilus Parvin, M.D., obstetrics and diseases of women and children; R. N. Todd, M.D., principles and practice of medicine; Thad. M. Stevens, M.D., medical jurisprudence and toxicology; and Henry Jameson, M.D., chemistry.

The College of Physicians and Surgeons continued from 1874 to 1878, when it was combined with the Indiana Medical College, thereafter known as the Medical College of Indiana, which for a time was the medical department of Butler University.

The Central College of Physicians and Surgeons was organized in 1879. The familiar names of Pearson, Haymond, Moffett, Haughton, Smythe, Lyons, Stone, Brayton, Sutcliffe and Joseph Eastman were among its faculty.

The union in 1906 of the Medical College of Indiana, the Central College of Physicians and Surgeons, and the Fort Wayne College of Medicine under the name of the Indiana Medical College, the School of Medicine of Purdue University, the organization of the State College of Physicians and Surgeons in 1907, which united with the Indiana University School of Medicine the same year, under the latter name, and the union of the Indiana Medical College with the Indiana University School of Medicine in 1908 is common knowledge to all of you.

In 1897 the present medical law was passed, which amendments have since strengthened, which gave medical education a decided recognition as a function and duty of the state. When this law was written there were seven colleges and so-called colleges in Indiana and all were dependent upon fees received from the students and occasional contributions from the faculty. At present, after the lapse of thirty years since the passage of this law, there is but one medical school in Indiana and it is a department of the State University and supported by the state, with a fine clinical group consisting of the Long, Riley and Coleman Hospitals, a recently enlarged medical school building and a new home for the nurses' training school, all within three squares of the Indianapolis City Hospital. A movement is on foot to convert the area between the City Hospital and the University Hospitals into a park, and the near future gives promise of a great medical educational center in Indianapolis as a result of state and city co-operation.

No attempt to review the history of medicine in Indianapolis is complete without especial mention of Dr. John S. Bobbs. He was the outstanding figure in the development of medical teaching and upon his death bequeathed to the Medical College of Indiana two thousand dollars for the establishment of the Bobbs Free Dispensary, and five thousand dollars for the establishment of a medical library. Dr. Bobbs is known in the history of medicine as the "father of cholecystectomy," having first opened the gall bladder. This operation, a cholelithotomy, was performed June 15, 1867. The patient, a woman of thirty years of age, made a complete recovery. She died at the Deaconness Hospital in Indianapolis only some eight or ten years ago.

A bronze tablet in the Indianapolis City Library bears the following memorial tribute:

In Memoriam

John Stough Bobbs
1809—1870
Illustrious Surgeon,
Patriotic Citizen,
Self-sacrificing Benefactor
Servant of God Through
Service to Mankind

"The skill of the physician shall lift up his head
And in the sight of great men he shall be in admiration."—Ecclesiasticus.

First to perform the operation of Cholecystotomy.

This tablet was placed here by the members of the faculty of the Indiana Medical College—1916.

Likewise Dr. Joseph W. Marsee, who was professor of surgery and dean of the Medical College of Indiana for several years prior to his death in 1898, is worthy of note. It is said of him that though he wrote comparatively few articles he was a surgeon of rare skill and mechanical ability and a great teacher. Those living who were privileged to receive instruction from him speak in enthusiastic praise of his high qualites as a teacher and surgeon.

The medical profession of the city is particularly indebted to Dr. George W. Mears, whose connection with the various medical colleges as a teacher of obstetrics covered a period of thirty years. In appreciation of his father's services, his son, Dr. J. Ewing Mears, long professor of surgery in Jefferson Medical College, gave his father's library and his own library to the City Library of Indianapolis in co-operation with the Marion County Medical Society for the creation of a medical library. The profession of Indianapolis and the state of Indiana co-operated in the creation of the Mears Library and many volumes were then added to the Mears collection by the physicians of this city and state.

I have realized the value of the work of our fathers in medicine in Indiana in my recent search for material for this paper. It would seem that there has not been an adequate interest in medical history and medical tradition on the part of our own local profession and I feel that we should awaken to its interest and importance and try to preserve the records as fully as possible for our own benefit as well as for the inspiration and enlightenment of those who follow.

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BABY WITHOUT ARMS OR LEGS

(Brief History with Photograph)

M. D. PRICE, M.D.

NAPPANEE

January 19th, 1928, at 11 a. m., I was called to the home of Mr. S. to deliver his wife. It being a breech presentation, one could easily determine a babe coming without legs. The labor was well in progress and within a half hour the delivery was complete. To our astonishment there was a babe born completely devoid of arms and legs.



Armless and Legless Baby at Age of Eight Weeks

After making a close study of the case we decided on an embryonic type of malformation, which was verified by Dr. Willis, of South Bend, who came and took x-ray pictures and found the acetabulum and glenoid cavity empty.

We were unable to find in medical history any report of malformation just like this one. The weight was five and one-half pounds; the circumference of the head, fifteen inches; length of body and head over all, thirteen and three-quarters inches; fontanelles normal; body, head and face well formed, with eyes, ears, and nose normal, except a tinge of birth mark over the nose.

Father's age is forty-two; mother's age, twenty-seven. This being the second marriage, four children were born to this mother, ages ranging from four years to eight weeks, including this babe.

The baby did very well for a few weeks, had a healthy cry, and could twist its body and move its hips as though it were attempting to move its legs. Being a bottle fed baby it did not thrive well and at the age of six weeks contracted the "flu," from which it died two weeks later.

TULAREMIA*

REPORT OF A CASE

ALFRED S. GIORDANO, M.D.

SOUTH BEND

The purpose of the following case report is to offer additional data regarding the presence of tularemia in rabbits in Indiana.

Since Francis in 1921 named the disease numerous cases have been reported with a wide geographic distribution extending from the Atlantic to the Pacific coast and from the Canadian to the Mexican border. The only cases from Indiana are two reported by Asbury in 1926. Perhaps a brief review may be of interest.

Tularemia is an acute infectious disease characterized by an early bacteremia usually running a chronic course and rarely fatal. Francis after a study of 323 cases has described four clinical types: (1) The ulceroglandular, which begins as a papule and later ulcerates through the skin and spreads through the regional lymph nodes; (2) oculoglandular, beginning as a conjunctivitis with subsequent involvement of the regional lymph nodes; (3) glandular; with or without primary lesion; ((4) typhoidal, without primary lesion or glandular enlargement.

The disease is transmitted to man by the bite of an infected horse-fly or wood-tick and by contamination of his hands with the body fluids of infected animals, most commonly the rabbit. The latter method of self-inoculation has been the cause of most of the human cases as it occurs during the dressing of the rabbit.

The most common types in the human are the ulceroglandular and the oculoglandular. The incubation period varies from one to nine days. The onset is sudden, ushered in by headache, chills, fever, bodily pains, sweating and even vomiting. After twenty-four hours the regional lymph nodes begin to enlarge and become painful. This is followed within the next twenty-four hours by the appearance of a papule at the site of infection which gradually ulcerates and discharges a thin seropurulent fluid. The following case is typical of the course of the disease:

Mr. F. H., age forty, butcher by trade, seen in consultation with Dr. A. A. Kramer. On November fourth the patient had dressed a number of rabbits killed during a hunting trip in woods near Culver, Indiana. He noted that some of the animals had large nodules about the head. On cutting the head off one of the animals he noted a grayish fluid coming out of one of the larger nodules. November eleventh he was taken suddenly ill with chills, fever, bodily aching and headache. Patient regarded this as a "cold" and did not consult physician until the next day. The fever then was 102 degrees F. and pulse 100. The skin was dry and the tongue was coated. The condition remained about the same except for in-

*From South Bend Medical Laboratory.

creased nervousness, chilly sensations and anorexia. On the fifth day patient began to complain of slight pain in the region of the elbow. Careful examination revealed slightly enlarged epitrochlear lymph nodes which were sensitive to touch. The next day the lymph nodes were found to have increased in size and a red streak could be traced to palmar surface of the left middle finger where the patient had noted a small blister the night before. The blister developed into a small indurated ulcer from which a thin purulent fluid exuded. Smears made from this fluid revealed absence of bacteria and cultures on various media remained sterile. The epitrochlear lymph nodes continued to enlarge and later the axillary lymph nodes became involved. On the ninth day of the disease the leucocytes numbered 11,500 per cmm. Blood was injected into the peritoneal cavity of a guinea pig and it died within forty-eight hours with characteristic lesions of tularemia. Blood culture remained sterile and the blood serum did not agglutinate B. Abortus or B. Melitensis, but the sample submitted to Dr. Francis at the Hygienic Laboratory agglutinated B. Tularence up to one to twenty. The temperature gradually fell to 98.6 on the eleventh day but again rose to 100.2 degrees F. on the twelfth day. At this time another sample of blood was obtained for animal inoculation and agglutination. The serum agglutinated B. Tularence in a dilution of 1 to 640, but did not agglutinate B. Abortus or B. Melitensis. Blood injected into the guinea pig failed to kill or infect the animal at this time. In the meanwhile the ulcer gradually became smaller and the lymphatics leading from the ulcer to the axilla could be felt as a beaded chain while the epitrochlear lymph nodes became larger and fluctuated. The temperature still fluctuated between 99 and 101 degrees F. and the lymph node was incised. During the following week the axillary lymph node became soft and was also incised. Within ten days the temperature gradually fell to normal but the patient felt very weak and is now gradually regaining his strength.

The onset and course of the disease resemble somewhat those of undulant fever due to Brucella Abortus, to which it is somewhat related serologically in about fifty percent of the cases as shown by Francis. However, the ulceroglandular and oculoglandular types are easily differentiated from undulant fever even though the serum may agglutinate B. Abortus in low dilutions.

SPECIAL ARTICLES

THE PHYSICIAN'S WILL

F. A. Schack, Trust Officer,
First National Bank of Fort Wayne

(Editor's Note: If there is any class of men more likely than any other to overlook the importance of making a will, it is the purely professional group—physicians, surgeons, etc. He is interested in his profession, *per se*, and, therefore, is likely to delay indefinitely the "putting of his house in order." How fraught with danger is procrastination on this subject is pointed out in the accompanying article. It is full of facts that every physician should know, and we believe it will hold your interest to the end. We commend it to you most heartily.)

Who invented wills? No one knows. But this is known: That at the very dawn of written history we find them in a high state of development, and that actual examples of these instruments are available, representing every epoch from those remote days to the present. One of the earliest examples is from Egypt, B. C. 2548, and it is said that so modern does this particular papyrus (which is a writing paper of the ancient Egyptians) appear that one thinks it might still be probated if it were not that the witnesses have been dead some 4,400 years. For your indulgence, we quote the example:

"I, Uah, give to my wife, Sheftu, the woman of Besab, all things given to me by my brother, Ankh-ren. She shall give it to any she desires of the children she bears me. Lieutenant Gebu shall act as Guardian of my son. Done in the presence of these witnesses: Kemen, Decorator of Columns; Apu, Doorkeeper of the Temple; Senb, son of Senb, Doorkeeper of the Temple. Second year, Amenemhet IV."

Society has recognized an old saying in America, "A man ought to die in harness;" however, seldom does a man have the opportunity to calmly and painstakingly set his house in order, liquidating his speculative holdings, realizing on his assets, settling up his liabilities, and investing his estate in a type of securities his family could lock away and forget. Society, therefore, early recognized this very fact and by law provided the right to name a business manager, capable of stepping into the deceased's shoes and doing these things for him. This right is the right to make a will and designate a proper executor. It was poet Young who said: "All men think all men mortal but themselves." It is difficult to suppose any rational creature so void of consideration as to postpone the arrangement of his affairs because he is young and healthful. Poet Young further says: "Be wise today, 'tis madness to defer." What a tremendous irritation must it not produce when postponed 'til the "last hour." Therefore, *make your will* and enjoy that peace of mind that follows the performance of a duty.

A will is nothing more than your wish placed on paper. It's often called a sacred document, but it does not really become a sacred document until the maker departs this life, and surely then there must be a real satisfaction to such an individual to know that his house is in order and that he has placed his wish on paper, in order to protect and provide for his loved ones. We stated that it was nothing more than "the maker's wish" placed on paper, and that is really true. There are many inhibitions which people often foolishly permit to militate against the making of a will: a superstitious fear that the making of a will may hasten

death; a sense of inadequacy or incompetency to plan for the future; a shrinking from the giving of confidence to a lawyer or to a friend competent to advise; the expectation that a little later the mind will be "better made up;" the dread of expense in paying for competent legal advice; or sheer hesitation and procrastination which may be the bane of any person's activities. You will find that almost everyone is convinced of the wisdom of "every other man's" preparing seasonably for the unforeseen emergency of the future.

There are many reasons why an individual should make a will. The very process of thinking through one's property and what to do with it helps one to evaluate his estate and put it into better condition. It becomes a housecleaning and purifying process. The making of your will the first time assists one in making a better will later. It is a reasonable view to take in regard to the first will made,—not as a final will which is rigidly fixed for all time to come, but as an instrument which, if unsatisfactory, may at any time be changed easily. An individual may change his will either by tearing it up and making a new one, or it may be modified by codicil, — in other words by making material alterations or amendments, or it may be wholly superceded and rewritten by a superior document. An individual may not expect to possess all wisdom at the outset and make satisfactory and equitable arrangements on his first endeavor. The process may properly be regarded as educational in the direction of wisdom and equity. We know that life is uncertain and that it is unfair to the cherished purposes of a man's lifetime to leave these purposes unexpressed and subject to the sudden emergency of disease and accident. At any moment an automobile, operated by another person, may make a will of the utmost importance. There are the loved ones of the family circle and then also certain approved objects of a man's best intentions, which have a just claim upon his thoughtfulness and promptness at a time where he is in good health and undisturbed by the shock of disaster. Certainly real satisfaction and contentment come to the man who has done the best he can in making provisions for the future, for peace of mind in large measure follows the writing of a will. When the individual with foresight passes on, it is then that his wish, which he has taken the time to place on paper, really becomes a sacred document, which is, in every sense, an expression of law as soon as the same has been probated and placed on record in the court. It then becomes as binding upon all persons and possessions therein named, provided it be legally drawn, as though it had been formulated by a State Legislature or an Act of Congress of the United States. Therefore, every testator becomes a law maker, and the court, after his death, sets itself to determining and executing his will as he has written it.

Still, some people will say, "Why should I have a will?" or "A will might add or lead to litigation." We will touch on some of the high spots in the reasons for making a will. Of course, if there is no will, then the estate passes by the law of descent. In most cases, therefore, it is advisable to have a will and in no case can it do any harm. The question, therefore, can hardly be answered generally. There is, for instance, the husband and wife who own a piece of real estate jointly as tenants by entirety. They have nothing else. In this case, it is not necessary to have a will, because if one or the other dies, the property goes to the survivor without any court proceedings or inconvenience of any kind. This is true, notwithstanding the fact that there may be children who would not inherit anything. This does not necessarily mean because the wife has signed with the husband to procure a first mortgage or maybe signed her name to a conveyance of certain property that the real estate is in joint tenancy with the right of survivorship, because in every instance the wife must sign all mortgage papers or deeds of conveyance, even if the property is in the name of the husband alone. Each state has its laws of

Some Things You Should Know in Making Your Will: We assume that the introductory clauses in a will are quite familiar to the average person. It is noticeable of late that there are fewer wills opening with elaborate introductions, but instead open with a direct declaration that the document is the last will and testament and is published as such. Of course there are the usual expressions that the party is of sound mind and memory and that he further cancels all previous wills heretofore made. The will must be signed, sealed and published in the presence of two witnesses (in Indiana), who subscribe their names thereunto in the presence of each other and of the testator, and that they have so done must be expressed in the attestation. By publication is meant that the testator must declare to the witnesses that it is his last will. A will must be dated the day and year it is signed. In the publication of a will, it is not necessary that the witnesses be made acquainted with its contents. The charge for making a will by your attorney is trifling compared to the comforting reflection arising therefrom of having done your duty to the utmost to protect and provide for all who are dear to you. The consolation that you have supported the kindliness of your heart and the soundness of your judgment with the means of sure and adequate consummation is in itself compensation of great value.

descent, and these laws have been made to endeavor to suit everybody, but they do not suit anyone in particular. Individual cases cannot be covered by written laws. How often we hear of a case, and perhaps it may have come home to you, dear readers, in settling an estate. For instance: A person dies, he leaves no will, and his estate passes exactly where he would not have it go, and where it would *not* have gone, had this individual had the foresight to place his or her name on paper. Concrete examples could be given in this article of how nieces and nephews who, during the lifetime of an individual, have never paid any attention to their relatives; possibly they lived away; they were out of the city, but in every instance when they are notified of a death and find themselves inheriting cash or securities will immediately assemble at such a time in order to know just what is due them, and it is usually the case that the heir cannot get his or her share quick enough. This, notwithstanding that the deceased may have lived all alone, neighbors or friends may have taken care of, nursed, called on, perhaps given time and money to make a life comfortable and would be deserving of a goodly share of the estate for the services rendered during that lifetime. Further, by making a will a party has the right to name an executor; otherwise the court appoints an administrator to administer the same according to the laws of descent. An executor is the party who represents the estate, and is named in the last will and testament to carry out the will in its entirey.

The choice of an executor is very important. If an individual name his best friend, does he know that this friend may not precede him in death, or that such friend may be too busy with his own affairs, or that perhaps it may be the friend's first time to serve in such a capacity? He would not know where to begin and if "his friend" does not serve, either by waiving the appointment or having predeceased the testator, then the court must name someone to administer the estate. It is here that the value of administration of trust departments of banks and trust companies can be of great assistance. There is the practical perpetual existence of a bank through its trust department. In other words, in naming a bank the testator has the satisfaction of knowing that the manager of his estate will be here to carry out his wish, according to the letters of his last will and testament. The trust department of a national bank has been organized under Federal Reserve supervision, and its main business is the service that this department can render its customers and their friends. Of prime importance is the management of decedent's estates, and as trustee under wills. The excellent work of trust departments and trust companies in the administration of estates has of itself undoubtedly brought increased volume of business from year to year. They point with pardonable pride to the splendid record of achievement in the management and growth of estates; broadened and improved relations between trust departments and lawyers has been a most important factor. The surface of what a trust department can render through its service to its customers and clients has not been scratched, particularly in the management of estates. Many thousands of dollars annually are spent in carrying the message to the general public concerning the necessity and advisability of making a will or creating a trust, and also why a bank or trust company should be appointed as executor and trustee. Experience, of course, is a good teacher, and it is by this experience that estates are able to benefit by the many advantages of a corporate executor. There is a charge, of course, in the administration of estates by the corporate executor. This charge is regulated by the courts and must be approved by the court, according to services rendered. It is based on the size of the estate and the time and work involved in the settlement thereof. There are no two estates alike. Each must stand on its own merits. There is the probate of the will, the complete inventory, inheritance taxes must be determined and paid, as well as federal estate taxes fixed. Then there are petitions to the court from time to time, and at the end of the year comes the final accounting to the court of all of the details, both of receipts of income and all expenditures paid out in the settlement thereof. The charges by the corporate executor are nominal and in most instances are less than individuals would receive. When an estate comes to the trust department, it is the same as opening a checking account at the bank; each estate is given a number and each kept separate and apart from the other, and all details with reference to the said estate are kept intact. In other words, it is the business of a trust department to handle estates in being prepared at a moment's notice. Trust department work is, in itself, of a very confidential nature. The manager and his assistants and clerks must be able to hold their counsel, for very often a client confides every detail regarding his financial affairs and portrays his innermost wishes as to the disposition of his or her estate, giving the details of his family and business life, which he has never breathed to a living soul. It might be stated here that a trust department is very glad to discuss the management and settlement of estates and by its practical experience is able in very many instances to be of great benefit to its clients. The matter of a will is an attorney's business. We are very glad to work out the details of a will with our clients and have their attorneys prepare the same. We suggest that a will should be read over and reconsidered every twelve months. Your will may cover your every need for your beneficiaries today, but the same may be unjust and lacking in flexibility as years go on, and as your station in life improves. In other words, *keep your will up to date.*

WHY PERIODIC HEALTH EXAMINATIONS?*

The reasons for periodic health examinations are so obvious that hardly any argument for them is necessary. They detect the beginnings of organic disease or discover the existence of definite physical impairment of which persons are unaware.

Six reasons for such examinations are:

1. Many faulty personal habits of living, errors in hygiene and possible shortcomings can be brought out only by such examination. (For instance, routine examinations at Harvard are said to show about eighty percent of the students have bad posture.)

2. These examinations form an excellent basis for health education.

3. Cancer, kidney diseases, heart trouble, diabetes, apoplexy and other organic afflictions are on the increase and the secret in combating these maladies in every case is early diagnosis. Many more years will be added to this life span as new methods to cope effectively with the organic diseases are devised or discovered. Health examinations have a real place in the advancement of our national vitality.

4. Many times an individual is ignorant of defects which may retard his efficiency and keep him below par.

5. Experience from health examinations shows that at least three out of four persons have some physical defect which if corrected will enable him to be more efficient and happy.

6. The results of health examinations are to lengthen and enrich the life of the person examined.

A physical examination similar to the thorough health test commissioned officers of the United States Army are required to stand each year is advocated in the bulletin as a sound personal investment for every citizen of Indiana.

Although the periodic health examination will take more time and have a broader scope than the ordinary life insurance examination, the procedure is simple. To record his findings, the physician has what is termed a history form that he uses as a standard for his examination. These forms are sent out by the American Medical Association as a guide to all physicians. Through the practice of recording methodically observations and opinions as to the physical and functional fitness of persons passing through their hands, physicians will acquire an increasing skill and keenness in detecting early evidences of preventive curable conditions.

Health examinations, therefore, should be arranged for on an appointment basis and not merely as incidental to service for the sick during crowded office hours. An appointment is every way desirable, both for the patient and the physician, because it takes fully three-quarters of an hour to make a thorough examination.

*This article is prepared by the Bureau of Publicity of the Indiana State Medical Association and is published at the request of the Bureau. This is the third of a series of four bulletins prepared by the Bureau upon the subject of periodic health examinations.

TOBACCO ANGINA PECTORIS

Eli Moschowitz, New York (*Journal A. M. A.*, March 10, 1928), reports four cases in which tobacco smoking caused symptoms closely resembling the angina pectoris of coronary or aortic disease. The variety of tobacco used apparently makes little difference, although the author's cases, in the main, resulted from smoking Turkish and Egyptian cigarets. The pains of tobacco heart have the following characteristics distinguishing them from those resulting from coronary or aortic disease: 1. The pains are more intense and of longer duration in tobacco angina than in true angina. 2. The pains are more likely to arise during complete rest, and may even awake the patient from a sound sleep. In true angina the attacks are usually induced by exertion, especially after a meal, and by emotion. In these particulars, the pain of tobacco poisoning resembles the true neuralgias. A prominent feature is the apparent sensitization that occurs. In a number of the author's patients, a greater or lesser degree of pain was induced by mere puffing of a cigaret, or even when the patient was in an atmosphere of tobacco smoke. In three of the patients there was no objective evidence of cardiac or vascular disease, as determined by modern methods of examination; nor were there in the interval between the attacks or subsequently any subjective evidences of such disease. In the other case, there was evidence of disease or disturbed function, as shown by blood pressure determinations, teleoroentgenograms and electrocardiographic determinations. In three cases the electrocardiographic tracings showed some changes suggestive of the intraventricular conduction disturbance, a condition associated with the clinical syndrome of angina pectoris. There are a number of ways in which the use of tobacco may be related to this condition: 1. There may not be any relation, and the anginoid pains may have ceased not because but in spite of the discontinuance of smoking. The mere cessation of symptoms after discontinuance of smoking is not final proof that tobacco was the cause, although in one case all the symptoms recurred at three separate intervals soon after the resumption of the old habits, and gradually ceased after the discontinuance of smoking. The tobacco may have caused sufficient sclerosis of the coronary arteries or aorta to induce angina. The use of tobacco may have caused subjective disturbance in a patient whose heart was seriously injured; in other words, the tobacco is merely the exciting cause in a patient with potential angina. This is by far the most likely view and is a strong argument for forbidding tobacco to patients with true coronary or aortic disease entirely and forever. To limit the use of tobacco in patients suspected of tobacco poisoning is not enough. Withdrawal of tobacco should be complete.

ACTION OF OILS IN MUSCLE TISSUE

Louis H. Jorstad and Frank H. Glenn, St. Louis (*Journal A. M. A.*, Jan. 7, 1928), state that the introduction of oil into muscle results in the production of tumors not unlike those in the subcutaneous tissue. Such oil tumors may, therefore, be a cause of undiagnosed pain in muscle. They not only may become a menace from the causes and under the conditions mentioned, but may produce general as well as local changes in the individual. The authors have observed fatty infiltration of the liver resulting regularly in animals fed a dietary high in vitamin A after a single injection of any of these oils. There also seems to be little doubt from their studies that any of these oils may be the seat of cancerous development, as cancers have followed the introduction of paraffin.

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Editor and Manager

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EDITORIALS

TEETH AND TONSILS AS FOCI OF INFECTION

The teeth and tonsils are considered the most common source of infection capable of producing physical disability. It is becoming more and more the opinion that so far as tonsils are concerned it is a difficult thing to say just when tonsils can be considered as harboring infection sufficient to cause a toxemia that may be damaging to the physical well-being. A very large tonsil may be innocuous whereas a small shriveled up tonsil having no particular signs of inflammation may retain within it infection that can be responsible for much trouble. Whenever a tonsil manifestly exhibits infection, as evidenced by retention of purulent or mucopurulent secretion that may be expressed by even slight pressure, then it is safe to assume that such tonsil may be guilty of being one of the sources of infection which is causing disturbances of many kinds including high blood pressure, rheumatism, neuralgias and other abnormalities.

The difficulty in deciding when the tonsils are guilty is in a measure duplicated when we consider the question of teeth as the site of focal infection. Dentists and internists have held varying views on this subject. Both seem agreed that evidence of infection as commonly interpreted on the radiograph is accepted as proof that such teeth should be sacrificed in the interest of the patient's welfare. Recently there is increasing evidence that radiographically negative teeth may be a greater source of systemic infection than radiographically positive teeth, since in the former there may be little resistance to infection. The positive teeth are characterized either by absorption of or increased density of the peri-apical tissue. Now it is thought that the pulpless teeth which do not show evidence of peri-apical changes do play a part in the production of physical disability. In a study of fifty cases of neuralgia, neurasthenia, gastro-intestinal distress, hypertension accompanied by headaches, dizziness, weakness and various gastro-intestinal symptoms, and low back pain by J. M. Lacey and C. R. Johnson (*California and Western Medicine,* May, 1928), each patient was studied in detail because of the presence of pulpless teeth, pyorrhea, or both, as the only positive physical signs or evidence of an exciting factor for the production of disability. The study of these cases in connection with the removal of some suspicious teeth led to the following conclusions:

First, radiographic examination of all the teeth and edentulous areas, combined with the clinical examination by a competent cooperative dentist, is essential in searching out foci of infection about the teeth.

Second, in the interpretation of radiographic evidence of infection all pulpless teeth and all teeth showing extensive absorption of the alveolar margins must be considered as active sources of infection.

Third, judging from clinical results obtained in our own cases, it is our contention that the removal of all pulpless teeth and of all teeth showing extensive infection of the gingiva and alveolar margins is entirely warranted as prophylactic and palliative curative measures.

PHYSICIANS' DIRTY OFFICES

The physician, above everyone else, not only should be clean in person and habit but his office should be the cleanest and most sanitary place in the community. That this is not always true can be seen easily by a visit to the offices of many doctors, especially in smaller towns and cities, and frequently in the outlying sections of larger cities. This subject was brought to the attention of the State Board of Health recently when a prominent woman, interested in public welfare, from one of the small cities of the state called at the office to inquire whether something could be done to clean up the offices of the two doctors in that city. She stated that these offices "were a sight" and were so unclean and so insanitary that the people of the town would rather be sick or take chances with a chiropractor or patent medicine than go to either of these offices for a consultation or a physical examination of any kind. This complainant was informed that the State Board of Health has no legal jurisdiction over doctors' offices. It was suggested that the good women of the town could have greater influence and could accomplish more if they would join together in a petition or a request to these doctors to clean up their offices. One of these doctors is the health officer of the town and as such is supposed to be interested in hygiene, sanitation, prevention of disease, clean foods, clean milk, clean water, and should, of course, set an example as an official to the rest of the community.

There is a moral to this story, in fact two morals, for this is not the first time that complaints of this kind have reached the State Health Department. The first moral is that the public generally is becoming keenly alive to the danger of uncleanliness, no matter where it may exist, and because the public is interested and is being educated to the danger of dirt, the public is demanding in no uncertain terms cleanliness on the part of all who would serve the public in any way, and physicians will not be exempt in this demand.

The second moral is that the chiropractor, the naturopath and the irregular practitioner, by whatever name he may be known, is always a past master in the art of advertisement and display. His office is usually clean, well-fitted and attractive, and he uses the art of cleanliness and display with telling effect upon the community. If an irregular practitioner should establish himself in the particular town (not mentioned), and fit up a clean and attractive office he doubtless would find himself head over heels in practice at once, not so much because of his ability, certainly not because of his superior knowledge, but largely because the people of the town would be anxious to show their appreciation of a clean doctor's office. John Wesley said, "Cleanliness is next to Godliness." Thomas R. Marshall said, "Cleanliness is essential to Godliness." A view of the offices of many, many physicians in Indiana would force one to the conviction that Godliness and doctors' dirty offices have little in common.

INADEQUACY AND INCOMPETENCY OF INDUSTRIAL SURGERY

The American College of Surgeons is making an endeavor to improve the character of industrial surgery and the conditions under which it is administered, the idea being that at present altogether too commonly men, women and children injured in industries are cared for in illy equipped and poorly operated hospitals by unethical and incompetent surgeons. Study of this subject will be broadened so that it will include pedestrians who are injured by railroads or motorcars. The ultimate aim is to have injured persons taken to institutions that are properly equipped and ethically operated and cared for by surgeons who are educated and trained for high type of service.

No one can doubt that this is a highly laudable ambition, and yet it is a question if it can be worked out, and for the reason that there is a deplorable degree of commercialism connected with industrial surgery of every description. First there are the insurance carriers who with few exceptions dictate to employers of labor where their employees shall be taken when injured, and it is not always the case that competent attention is sought. In fact, it is rather a common practice on the part of insurance carriers as well as industrial concerns that carry responsibility for injuries to employees to shunt responsibility whenever possible, employ inexperienced and cheap surgeons, and curtail the hospital expenses to the fullest extent. Therefore, one of the things that the American College of Surgeons could do or attempt to do is to educate the insurance carriers and the employers of labor concerning the advantages of furnishing adequate and competent service in industrial cases, and emphasize the fact that in the end the best is the cheapest.

MILK SURVEY IN INDIANA

The State Board of Health is making an intensive milk survey in a number of cities of the state for the purpose of determining the condition of milk supplies being furnished these cities. This survey is a part of the state-wide program for better control and supervision of milk supplies, which was inaugurated by the State Board of Health with the beginning of this year. The present survey is being conducted with the cooperation of the American Child Health Association. A portable milk laboratory is being used in which bacteriological and chemical tests of samples of all milk supplied to the cities are made. The portable milk laboratory is established at a central point for at least a week, and from this point samples of milk are collected from all cities and towns within a radius of twenty-five to thirty miles from the central station. The laboratory will be established for a week at various cities so that when the survey is completed, the information obtained will show a typical cross-section of the entire state. The survey is in charge of Frank C. Wilson, director of the Department of Milk and Dairy Products, of the State Board of Health. Mr. Wilson is being assisted by C. F. Chrisman of the Child Health Association, C. F. Langwell, state dairy inspector, and O. T. Law, state food inspector. The survey will cover a period of approximately twelve weeks.

MEDICAL SERVICE FOR ALL

Recently there has been formed a committee to study the cost and adequacy of medical care, the expense to the community of hospitals and clinics, and the return accruing to physicians, dentists, nurses, and other agents. This committee has representatives from private practice, public health, benevolent and charitable institutions and organizations, economics and the public. Its chairman is Ray Lyman Wilbur, president of Leland Stanford University, and an ex-president of the American Medical Association. The study will cover a period of five years and will be aided by a large number of cooperative agencies. The purpose for which this study is made is based upon the fact that a very large number of people are unable through economic circumstances to obtain adequate and efficient medical service and hospitalization, and it is hoped that the study will result in the adoption of some plan that will solve the problem.

We sincerely hope that the final conclusions of the committee will not be that the physicians individually or collectively must bear the burden that they do now in rendering much valuable service to the public for which no compensation of any kind whatsoever is paid. It is granted that adequate and efficient medical and surgical services should be available to every person in every community, but each community as a community should be responsible for that service, and there should be no shifting of responsibility to

the medical profession without the community obligating itself for compensation for the services rendered. In the final analysis it is quite probable that the committee will offer some such plan as that embraced in socialized medicine. We have no faith in the success of such a movement, and we do not believe it is a fair and equitable plan to put in operation. Socialism in any form is a Utopian dream that never has worked out satisfactorily and never will work out satisfactorily because it means the creation of a lot of dependents and paupers. It would stimulate indolence on the part of those who expect everything to be given to them without giving anything in return. We are highly in favor of the adoption of some plan whereby all of the people at any and all times may secure adequate and competent medical and surgical service, but we maintain, as we always have maintained, that the members of the medical profession should not be forced to pay the penalty of a policy that carries with it no discrimination as to whom service is to be rendered or make provision whereby the recipient of service shall pay for that service in proportion to ability to pay. Already there are too many means afforded for the creation of paupers and dependents without adding more.

The vital problem, as we see it, is to make it possible for any person to secure adequate and competent medical and surgical services at a cost which that individual can pay, and it is up to the medical profession to have the last word in what that plan shall be and how it shall be carried out. As the committee well says, "dentists, nurses and others engaged in the cure and prevention of disease surely are not getting rich at the expense of the sick." In fact the average physician, considering the ten thousand dollars or more invested in his education, the value of the time lost in procuring that education, is very poorly paid for the very high grade of service that he renders, and at the same time he actually is donating more service than those who follow any other vocation. The welfare workers, from managers to nurses and clerks, all are well paid, and the food and clothing merchants receive pay for their wares even when the wares go out in charity. The well-to-do can donate their thousands to charity and not feel it, but the average physician who, comparatively speaking, donates a great deal more, cannot afford it. Therefore, the plan adopted should be intended to relieve the physician of this unfair burden while at the same time no one is deprived of his services.

UNJUST TAXATION OF PHYSICIANS

It looks as though everyone takes a fall out of medical men. Two prominent Indiana physicians were "stung" for additional income taxes, heavily taxed on what the revenue department of the government calls "unearned income" arising through so-called profit on the work of assistants, and a formal protest lodged with the revenue department at Washington has been refused favorable consideration. As a matter of fact we quite agree with Arthur Brisbane's statement that even the taxes on the *earned* income of professional men are in a measure confiscatory, and this latest injustice in increasing the taxes on a physician's income on the false assumption that part of the income is unearned certainly is confiscatory and discriminatory. Right on the heels of the decision in this Indiana case comes the report that the congressional committee into whose hands the bill for tax redress for physicians was placed has refused favorable consideration, thus making it possible for a continuation of the practice of the government in taxing medical men for something that is not levied upon any other professional men or followers of any vocation. We fail to understand why members of the medical profession should be singled out for such imposition in the way of taxation, for there is no consistent reason why they should be penalized above all others. Certainly such discriminatory practices as those mentioned do not add to the respect which members of the medical profession have for their government. Physicians are perfectly willing to pay their just share of taxation, but they do object to confiscatory practices that are not applied to those following other vocations.

GOVERNMENT INGRATITUDE

THE *Bulletin* of the Indiana State Board of Health, in its April number, publishes the story of private John R. Kissinger who after becoming one of the world's greatest heroes, losing his health and almost his life in proving that yellow fever is contracted by the bite of a mosquito, and who after he became a hero almost starved to death in rich and prosperous America. In fact, private Kissinger for a long time was denied attention, finally was granted a paltry $100 a month only to lose it later, and at the present time is enjoying the bounty of generous-hearted people from all over the United States who have contributed to a fund to give him a home.

It may be possible, as charged, that there are many ex-soldiers drawing pensions not deserved, and that the government has been imposed upon thousands of times by those who have fought for their country, but the fact remains that our government never can repay any of the soldiers who have fought and been incapacitated in any manner as the result of war service. Furthermore, it is the most damnable of outrages that men of the Kissinger type, and there probably are hundreds of them who have made sacrifices for their country, are being denied even the necessities of life which they so sorely need and all because a rich and powerful nation has no gratitude and the pitiful sums doled out in the way of pensions is controlled by bureaucratic machinery that is hampered by an over-abundance of red tape and seemingly no regard for justice or fair play. We know

of the case of a young man who served throughout the late war and who had a progressing impairment of eyesight at the time of his discharge and since the war has become totally incapacitated from blindness. Through a technicality this young man has been unable to secure pension from the government. The last time we heard of him he was an object of charity. Ye gods! Is there anything in that episode to instill love of country in the rising generation, and is it any wonder that a great many of the boys who served in the last war are bolshevistic in their ideas now? How well do we remember the parades of soldiers going to the front during the last war, the cheers of slackers and others on the sidelines, the oft-repeated expression that there was nothing too good for the boys who were going to the front, and that when the boys returned from the war their jobs would be awaiting them? Have we kept faith with those boys? Indeed we have not, for many of them who left good jobs have been hunting jobs ever since the war closed, many who were sound mentally and physically when they went to the war came out physical and mental wrecks and not a few have committed suicide to end their troubles, and a rich and powerful government has refused to take care of them except in a niggardly way. The sins of omission and commission charged to the profiteers is nothing compared to the sins of omission and commission charged to our lawmakers and "hard boiled" pension adjusters who have failed to keep faith with the boys who fought in the last war. It seems to be the sentiment of Americans to one minute acclaim a hero and wine and dine him, and the next minute kick and abuse him. No matter what an incapacitated soldier may cost us in pension he has earned every bit of it and more, and our refusal to take care of our incapacitated soldiers in a manner that will insure them comfort is nothing short of a national disgrace.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

WHILE making his first shopping tour with his wife a young man died suddenly in the dressmaking department of one of Chicago's largest department stores when he learned the cost of women's clothes. The shock was too much for him. The question is, can the department store be considered liable?

SOME of the state medical associations are making a feature of health examinations for members during annual sessions, the appointments for the same being made when registering. In some instances the members' wives are included in the scheme of popularizing health examinations. Why not put the plan in operation at the Gary session of our Association?

WE quite agree with Dr. Charles H. Mayo, who says that the metric system should be standardized for universal use, but we do not agree with him when he says that "it is generally employed by the medical profession." If he will look over the prescriptions in any average drug store he will find that not one out of twenty physicians uses the metric system, though we admit that it is a pity that all do not do so.

JUST how many physicians will be honest with themselves when they pull the lever in the voting booth this fall? We'll bet ten cents to a punched nickel that the majority of them will vote as they always have—the party ticket, irrespective of the character of the men on the ticket. We desire to say, even though it does no good, that there are names on both tickets that should be scratched by every self-respecting medical man who has the best interests of the medical profession in mind.

CONCERNING dishonesty of medical witnesses in the courts of law, the *Atlantic Medical Journal* for May says, "It is time for action. We should start to clean house from within, and every county medical society having satisfactory proof of any of its members being dishonest in giving expert testimony should require such member to show cause why he should not be dropped from membership. He should be given pitiless publicity. In this way he would be reformed or driven out of organized medicine."

WELL! WELL! Who says you can't buy cocktails openly and under the sanction of prohibition authorities? Who does not know about Angostura Bitters, advertised as "containing about forty-five per cent alcohol" (good whiskey contains only forty-five per cent alcohol) and as being "absolutely free from injurious drugs." The advertised dosage is one tablespoonful but of course why stop at that dose? You can get a good "kick" out of a couple of tablespoonfuls of bitters, equivalent to Riley's "Slug of Rye."

A WRITER in *Medical Economics* for February says that many physicians have failed to realize that the standards of living have advanced and consequently remind practitioners that unkempt

offices lacking equipment and in other ways offering a poor grade of service are inadequate. It is up to the medical profession to show the public the newer types of service. The public is willing to pay for adequate and efficient service, and it is up to the present-day physician to supply that kind of service if he expects to succeed.

Sufficient evidence is available to prove that certain Indiana physicians are sending samples of blood to the state laboratories for Wassermann tests, free service, and then charging their patients for the service. Other physicians are getting the free service from the state laboratories and giving their patients the advantage of it, no matter whether the patients are able to pay for the service or not. Well, as we have been saying, state medicine is coming, and we believe that medical men are helping it along more than anyone else.

Some of the churches now are squabbling over the question of whether or not they shall admit colored people as members and communicants. It is quite possible that a garlic-eating native of southeastern Europe is every bit as desirable for close contact as an ill-smelling negro wench, but who wants either of them in his pew at church even when listening to a sermon on brotherly love? Well, as the old maid said, "There is a time and place for everything," and for various reasons we believe that segregation has a place in our social fabric.

Again the report comes to us that physicians are signing death certificates for Christian Scientists, and we are at a loss to understand why any physician worthy of the name should be guilty of such duplicity. Isn't it possible that a physician who becomes the tool of the Christian Scientists is covering up something that should be known publicly, even to the courts? The best way to treat a Christian Science death is to turn it over to the coroner, and no coroner should sign any death certificate until he knows the cause of the death through an autopsy.

With every year's subscription to *Hygeia* the American Medical Association is giving a copy of the Life of Pasteur. *Hygeia* is good without any premiums, but it would be just as well to remember that this interesting biographical volume is an added incentive for the placing of *Hygeia* subscriptions. To speak frankly we never have understood why every physician in the land has not subscribed for *Hygeia* if for no other purpose than to have that wonderful magazine of individual and community health lying on the reception room table for patients to read.

The primary has brought forth some prizes in the way of nomination of candidates for office who by all the rules of the game are not entitled to recognition. However, nomination does not mean election, and if we are not mistaken there are many surprises in store for some of the Indiana politicians. From the standpoint of the physician, there is not much choice between democrats and republicans insofar as candidates for some of the offices are concerned, though in a few instances physicians will show little concern for the traditions of the profession if they vote for some of the men that have been nominated.

We still meet occasionally the man who walks into a doctor's office, sticks out his tongue and says, "Doc, what's the matter with me?" and expects a casual examination of his tobacco-stained tongue to be sufficient to make a diagnosis of anything from brain fever to constipation or ingrowing toenails. Furthermore, we are sorry to admit that there are some physicians who fall into the habit of trying to make a diagnosis without a careful and painstaking examination, and then they wonder why they fail to succeed in the practice of medicine. Get the habit of making a real examination, and don't pass any opinion until you know what you are talking about.

In Chicago the officials withheld information concerning the amount of taxes assessed until after the primary election. When the taxpayers received their announcements they found that the city and county taxes had been boosted tremendously, some city residents having their taxes raised 100 percent, some 200 percent and some 1,000 percent. Evidently there was no redress, for taxes had been assessed to meet a deficit and were in keeping with existing legislation. What else could be expected when officials spend money like drunken sailors? However, we can sympathize with Chicago taxpayers, for some such program has been attempted here in Indiana.

It may be interesting for our members to know that the medical defense committee of the Association is almost constantly having a controversy with attorneys concerning fees to be charged in malpractice suits. It seems strange that when an attorney is employed to defend a physician he should seize upon the opportunity to charge several hundred dollars for a few hours' work, and yet that is exactly what happens in the average case. Those same attorneys would yell like stuck pigs if charged proportionately by a surgeon for saving their lives, and the family physician could attend any one of them every day for a year and not be able to collect as much as charged for services in a two-day malpractice suit.

In his observations on 20,000 Wassermann tests, Dr. S. F. Service, in the *Clifton Medical Bulletin* for April, says that among 217 patients giving a positive Wassermann, fifty-eight percent of this number had no previous knowledge of

having had syphilis, though twenty percent of those having no previous knowledge of syphilis admitted gonorrhea, so that the original infection was probably a mixed one. Five percent of those having no previous knowledge of the disease had no clinical signs which would help in making a correct diagnosis. The conclusion is, therefore, that a history of gonorrhea should always be an indication for a Wassermann test, and that clinical signs or symptoms of syphilis are absent much more commonly than is supposed.

MACFADDEN, of the Macfadden Publications (*Physical Culture*, etc.), now is trying to secure some endorsements from medical men, and he has the monumental nerve to try to create the impression that he knows more than physicians and that all of the physicians are wrong except those who believe that physical culture will cure all manner of diseases, even syphilis. He is sending out postal cards for physicians to sign as an indication of their belief in the Macfadden bunk. It is fair to assume that this so-called endorsement will be used for advertising purposes and to the profit of Macfadden, who already has fattened at the expense of a credulous public and also would fatten at the expense of a credulous medical profession if any of the profession are so foolish as to fall into his trap.

AMONG our exchanges we find a number of foreign medical journals, and we note the rather general tendency of those journals to carry not only liquor advertisements but the advertisements of many proprietary and pharmaceutical preparations that could not obtain recognition in any reputable medical journal in the United States, for, thanks to the work of the Council on Pharmacy and Chemistry of the A. M. A., most of the unworthy pharmaceutical preparations are stamped with disapproval. The physicians of the United States should be thankful that they are so well protected against unscrupulous and dishonest manufacturers. However, the trouble in this country is that physicians do not protect themselves by taking advantage of the means that have been offered for the purpose.

THE man who nurses a grudge is potentially a dangerous man. This is particularly true in the case of a physician who because of his vocation has so many opportunities to stir up ill feeling and which, if encouraged, ends in trouble for himself as well as others. Just why the practice of medicine should make a man suspicious and resentful is a little hard for the average individual to understand. However, it is a condition that exists, and the profession as a whole ought to bend its energies to the task of improving the situation and limiting the sphere of influence of those who are happier when they are tearing down than when they are building up. This means that in our medical societies we must individually and collectively try to build up a spirit of cooperation and helpfulness as well as tolerance.

No doubt there are some physicians who are dishonest enough to submit patients to totally unnecessary operations either for the purpose of gaining experience or acquiring fees. We hope that the practice is very limited, even though we suspect that it is commoner than generally supposed. We do know that some of the surgeons connected with the work of the Veterans' Bureau are guilty of submitting ex-soldiers to operative procedures that by the wildest stretch of imagination can not be considered as indicated or offering the slightest benefit to the patient. The practice deserves severe condemnation, and especially when some down and out ex-soldier has been made infinitely worse as the result of bungling in the experimental work of some physician of the Veterans' Bureau.

AGAIN we desire to urge the members of our Association to assist in arriving at definite conclusions concerning the amount of prescribing and dispensing done by the physicians of the state. Therefore, the questions that have been propounded to every physician of Indiana should be answered, and those questions are as follows:

1. To what approximate percentage of your patients do you dispense medicine?
2. Do you find the knowledge and service of the druggist always satisfactory in filling prescriptions?
3. What, in your opinion, is the tendency of the profession relative to dispensing medicines? Is it increasing or decreasing?

Answer these questions and send your answers to the secretary of the Association, at 804 Hume-Mansur Building, Indianapolis.

AN Indiana optician advertises in the daily press that the fitting and prescribing of glasses is but an incidental part of his work inasmuch as his real function in business is to advise people concerning the health of their eyes. He starts his announcement by saying "We prescribe for the eyes," and he lives up to that announcement, for it is known that he does not hesitate to give medicine or prescribe medicine for what he thinks is a pathologic condition, and yet we have a medical law that is supposed to protect the people from anyone practicing medicine without a license. We used to think that conditions were improving so far as concerned education of the public in the matter of fitness for following any profession or business and the adoption of standards covering qualification of work, but there is much to change that attitude and create the impression that things are getting worse rather than better.

THE library of the Indiana University School of Medicine is desirous of obtaining some back

numbers of The Journal of the Indiana State Medical Association to complete its files. They need the following: Volume 3, 1910, Nos. 1, 3, 11 and 12; Volume 4, 1911, all needed except No. 11; Volume 5, 1912, Nos. 1, 3, 9 and 12. The library also is desirous of obtaining any volumes of other medical journals published in Indiana (there have been about fourteen), many of which have been merged or discontinued. It is probable that many doctors have bound or unbound files of these old journals which they do not especially care for, and which would be used advantageously at the University Library. If any reader has any such journals, will you kindly send them, by express collect, to the Librarian, Indiana University School of Medicine, Indianapolis, and mark your parcel "Value less than ten dollars." The University will appreciate your courtesy and generosity.

Dr. Charles H. Mayo is quoted as having said, in Los Angeles, that "ladies' legs really are an interesting study now days," and most men will agree with him. In fact, most commuters in our cities can study legs from beginning to end without any difficulty, but the Rochester surgeon's observation is based on his discovery that the shape of the female leg is changing as a direct result of too little exercise and too many high-heeled shoes. In reality we haven't been as observing as Dr. Mayo, so are not qualified to say anything about changing shapes. We note that ladies' legs are of various sizes and shapes, but whether they are different than they used to be in olden times we are unprepared to say, for only within very recent years has it been possible to see the female leg from start to finish as a regular public exhibition. As a matter of fact if female legs are fairly plump they suit us both anatomically and æsthetically. However, as the author of the "Two Black Crows" says, "Why bring that up anyway?"

The Methodists and the Presbyterians are renewing the controversy over the theory of evolution, and from newspaper reports we learn that a very prominent New York Presbyterian minister in answering the question as to whether he believed in the virgin birth of Jesus, said, "I don't know." To most medical men science or scientific truths are acceptable in preference to legends, mere theories or speculations. As to its effect upon righteous living and the prospects of getting into the Kingdom of Heaven, what difference does it make whether we believe in the evolutionary theory or not, or subscribe to the dogmatic version of the virgin birth of Jesus? As a matter of fact more physicians would be members of churches and constant attendants at religious services if there were less creed and dogma in the religious teaching of today, and just a little more display of the spirit of the Lowly Nazarene by some of the ministers and ardent church workers. Religion ought to make a man better, but no religion, if it aims to fit every individual into a certain groove, is going to accomplish the most in the world.

In many localities in Indiana and other states people have voted on the question of the adoption of daylight savings time. It certainly is amusing to find prominent physicians divided in their opinions concerning the value of daylight savings time *from a health standpoint.* We had supposed that medical men were fairly well united on the subject of more sunshine and fresh air as an aid to health, but it seems that in discussing this daylight savings time question some doctors are arguing that a little more sunshine and outdoors cuts little figure. Coming down to cold facts, don't the people vote on this question according to their personal conveniences as well as likes and dislikes? The railroad man doesn't want daylight savings time because it differs from standard time, which governs his hours of work. On the other hand, the shopmen very generally like daylight savings time because it gives them a little longer daylight for recreation for themselves and their families after their hours of work are over. In reality what we ought to have is one kind of time and less variation in clocks and there would be no confusion.

An eastern radio station is broadcasting humorous talks by a well-known comedian who has a take-off on each of several trades and professions. Not long ago he told about a man who had a pain in his heel and consulted different physicians concerning its cause and cure. One physician advised removal of the tonsils; another advised removal of one or more teeth; still another advised that the appendix be removed: and everywhere the patient went he received a recommendation to do something a little different, but always at considerable inconvenience, expense, and sometimes discomfort. Finally the patient consulted his old family physician who had been forgotten during the efforts to secure the highest type of service. The old family physician examined the patient's shoes and discovered that there was a nail sticking up in the heel, the removal of which cured the patient. As a mere side issue this is an old story, but it is just as appropriate now as when first told, and it emphasizes our contention that there is altogether too much of a tendency on the part of many physicians to be superficial in their examinations as well as too apt to jump to conclusions.

Recently we heard a physician say that high blood pressure does not signify anything particularly wrong with the human body, as many people have a persistently high blood pressure that is peculiar to them and should not be considered an abnormality. That is a fine line of talk for an educated and experienced physician of this day

and age to get out of his system. He might as well have said that a temperature of 105 means nothing and should be considered peculiar to some individuals. We suggest that the physician to whom we referred should read any recognized book on blood pressure—cause, effect and remedy, which will point out that foci of infection ultimately will result in increased blood pressure, and which, if unrecognized and removed, will result in serious consequences. As a matter of fact one of the most forceful arguments that can be presented to the layman concerning the value of periodic health examination is the fact that it is possible through frequent physical inventories to discover foci of infection which may exist in out-of-the-way places in the body, and by removing them prevent the advance of pathologic changes which result in high blood pressure and the dangers that go with it.

WE are very much in sympathy with the movement to establish a branch of the Woman's Auxiliary of the American Medical Association in every state in the union, providing the spirit back of the movement is an attempt to make the auxiliary practically helpful to physicians in their everyday work. If the Woman's Auxiliary is going to be another social or dinner organization, largely devoted to popularizing and glorifying a few women who are happiest when they are in the limelight, and the organization begins to co-operate with various welfare organizations that are sapping the vitality of the medical profession, then we are opposed to the enterprise. Already we have noted the tendency on the part of some of the branches of the Auxiliary to unite with various uplift societies in work that is nothing short of socializing medicine and encouraging pauperism and dependency. If the wives of physicians, banded together as an organization, do nothing more than point out to their lay sisters in various women's clubs the dangers of misplaced medical charity and the reason for upholding ethical medicine, they will serve a real purpose as an auxiliary to the A. M. A. On the other hand, if the Woman's Auxiliary is going to give aid or comfort to a lot of uplifters who are not consistent or rational in their efforts to better mankind, then it would be better if the Woman's Auxiliary had never been given birth.

AT present there is renewed activity in Indiana in connection with the exploitation of the Radithor humbuggery. The physician or dentist who invests in Radithor or recommends it to patients is a fit subject for the feeble-minded home. Concerning this species of quackery we will reproduce what we had to say about it in the September, 1927, number of THE JOURNAL, and it is as follows:

RADITHOR.—This is one of the numerous pieces of quackery in the field of radio-activity. It is exploited by the Bailey Radium Laboratories of East Orange, New Jersey, the moving spirit of which is one William J. A. Bailey. The Radithor quackery consists of thirty half-ounce bottles of distilled water which is alleged to be radio-active. No less than thirty bottles can be purchased; and the price is $30. That is, the price to the sucker who happens to be a layman is $30; to the easy mark who can write M. D. after his name, it is $25. An order form " for Doctors' Use Only" states that "when patient buys direct, we allow doctors a $5 credit on all orders." The physician who would order Radithor must be weak not only in medicine but also in morals.—(*Jour. A. M. A.*, July 16, 1927, p. 208).

Incidentally, we wish to urge the members of our Association to read carefully the department, "Truth About Medicines," published in every number of THE JOURNAL. Oftentimes we receive letters inquiring about some fake like Radithor that we had exposed perhaps months before in the column devoted to "Propaganda for Reform," which is a part of our department known as "Truth About Medicines."

THE *Journal of the A. M. A.* "fell" for a lot of buncombe when it accepted the advertising of the California Fruit Growers Exchange and thus helped to distribute some cleverly conceived propaganda to the effect that the American people are suffering from acidosis which may be corrected by more liberal consumption of California oranges. In commenting upon this matter the editor of the *Boston Medical and Surgical Journal* (November, 1927) says, "The California Fruit Growers Exchange, we believe, is honest in its intentions. It wishes to sell more California fruit. Its advertising methods are bred from ignorance of professional ethics and the true nature of acidosis. *The Journal of the American Medical Association* has no such excuse, and its reasons for accepting this blurb are a mystery, particularly in view of the occasional policies of its advertising bureau in forbidding subscribing journals to accept the advertising matter of such reputable preparations as Phillip's Milk of Magnesia and Patch's Cod Liver Oil. We trust that the *Journal of the American Medical Association* will cause the withdrawal of this advertisement or give acceptable reasons for its publication." *The Journal of the A. M. A.* is not found napping very often, and particularly when it comes to pulling chestnuts out of the fire for someone else. Consequently we are rather surprised that the management of that periodical should have been taken in by the California Fruit Growers Exchange.

WE learn that the company exploiting what is known as the Radium Ore Revigator is attempting to put on a sales campaign in Indiana. The State Board of Health published an article in its monthly *Bulletin* in which the worthlessness of radium jugs was mentioned, and this article was reproduced in several of the newspapers throughout the state. While the Radium Ore Revigator Company's product was not specifically mentioned,

yet they evidently made the coat fit and at once put up a complaint, going so far, we understand, as to ask one of the leading newspapers of the state to publish a retraction. Evidently some of these commercial enterprises that impose upon the public have an idea that they can bluff their way through, and by threats of prosecution secure recognition if not endorsement. Our readers are reminded that the December, 1925, issue of THE JOURNAL, under "Propaganda for Reform," page 479, contained the following:

"Radium Ore Revigator.—Capitalizing the discovery of radium and radioactivity, water jars containing as a part of the wall of the jar or as an accessory low grade radio-active ore are being sold under the general claim that they render water that is put into them radio-active and that this radio-active water will 'make you well if you are sick and keep you from getting sick if you are well.' One of the most widely advertised of these devices is known as the Radium Ore Revigator, put out by a California company. From the advertising claims the impression is gained that ill health is caused by the lack of radio-activity in our drinking water, that the curative properties of certain mineral waters have been shown to be due to their natural radio-activity and that many ills are cured by the use of water from the 'Revigator' jars. Even if the water from the jars has the radio-activity claimed, this is so small that it has no therapeutic significance.—(*Jour. A. M. A.*, November 21, 1925, p. 1658)."

WE are getting just a little fed up on this health information in the lay press when it is conducted in a careless manner as so often is the case. Some of the stuff written by Evans of the Chicago *Tribune* has the appearance of having been prepared either while the writer was half asleep or while hurrying to catch a car, for it doesn't show evidence of very serious thought. We grant that it is difficult to have something good in every issue of a daily paper, but we believe that if a thing is worth doing at all it is worth doing well, so perhaps it would be better to cut out the health column occasionally rather than have it of poor quality. What is true of the health column conducted by Evans also is true of that conducted by Brady, Reed, Fishbein, and several others that might be mentioned. We are not going to be too severe in our criticism of the health columns when conducted by men who are capable through education and experience to give trustworthy information, but we do want to make a plea for more attention on the part of the average physician to the need of assisting in public health education through his contact with patients. This can be done by explaining in understandable language many of the theories and facts pertaining to individual and community health, and the knowledge we possess concerning causes and prevention of disease. Patients should be made to feel that they can go to the family physician for information, and, on the other hand, the family physician should seize upon the opportunity to give information that is trustworthy and free from technicality. In this way it will be possible to counteract the effects of much of the ignorance, superstition and irrational ideas that many people hold concerning cause, dissemination and cure of various diseases.

IN the May number of THE JOURNAL we commented on the attitude of the *New York State Journal of Medicine* in withdrawing from the Association of State Medical Journals organized and sponsored by the A. M. A. for the purpose of protecting its members from unethical or objectionable advertising. As a matter of fact we can arrive at but one logical conclusion as to the reason for such withdrawal and it is summed up in the one word "commercialism." It is very evident that the *New York State Journal of Medicine* desires to take some advertising which neither the *Journal of the A. M. A.* nor a very large majority of the state medical journals will accept. In other words that journal, which is in a better financial condition than some of the struggling state journals and should be ethical and set a fine example, boldly announces through its attitude that it proposes to lower its standards and accept objectionable advertising. As an evidence of the change of attitude its issue of April 15th has the following note at the head of the list of advertisers: "No advertisements of medical preparations can be inserted unless they have been approved by the Council on Pharmacy and Chemistry of the American Medical Association." This rule was changed in the May 1st issue to read as follows: "Advertisements published in *The Journal* must be ethical. The formulas of medical preparations must have been approved by the Committee on Publication before the advertisement can be accepted." What does a committee on publication of any state medical journal know about the reliability of medical formulas? Then we note that it starts out by carrying advertising that would not be carried by the *Journal of the A. M. A.* or a majority of the state journals. As a matter of further comment we desire to say that we think the *New York State Journal of Medicine* should be in better business than lowering its standards of medical advertising. If that journal is going to have low standards, why not cut loose from ethical medicine entirely and accept the advertising of Lydia Pinkham's Vegetable Compound, Pyso's Consumption Cure, and other nostrums?

IT has not been so many years since religious publications, editorially preaching all the rules laid down by the Lowly Nazarene, were carrying in the advertising pages the blatant and untruthful advertisements of the worst types of swindles of various kinds from worthless mining stocks to the most glaring medical frauds. As an excuse for carrying such misleading and deceptive advertising the plea was made that the publications would die for want of support except for the income from advertising. Fortunately sufficient

pressure was brought to bear to make most of these religious publications clean house, but there are a few of them that still carry very objectionable advertising because of the profit derived. What is true of religious publications also is true of some of the medical publications. Twenty years ago the manufacturers of worthless proprietaries and nostrums were able to advertise their products in almost any of the so-called reputable medical journals in the country. Many of these preparations were advertised in a thoroughly dishonest manner, and it was only after the American Medical Association put into effect its Council on Pharmacy and Chemistry that the real facts became known and the better class of medical journals refused to take the advertising of nostrums and proprietary preparations. At present nearly all of the medical journals of the United States, including the official journals as well as the special journals, follow the rules of the A. M. A., founded on the findings of the Council, in the acceptance of medical advertising. Unfortunately a few of the independent journals do not follow any rational rules in the acceptance of advertising, and such journals are a disgrace to the profession as well as to those who are responsible for their publication. Just why reputable medical men will subscribe for such journals, and why any advertisers will pay good money for advertising space in periodicals with circulation so limited that the publishers are unwilling to make a sworn statement of circulation is hard to understand. When a medical journal will carry the advertising of discredited nostrums and pharmaceutical specialties and then in its editorial columns talk about raising the standards of the practice of medicine, there is room for argument as to consistency if not a question as to the honesty of the management. Among our exchanges we find one medical journal, evidently supported by many highly ethical physicians, that carries an abundance of advertising that none of the official journals including the *Journal of the A. M. A.* will carry, and among which we mention Gude's Pepto-Mangan, Sanmetto, Robinson's Hypophosphites and allied preparations, Gray's Glycerine Tonic, Antiphlogistine, Tongaline, Ergoapiol, Prunoids, Cactina Pillets, Sal Hepatica, Peacock's Bromides, and borderline proprietary pharmaceuticals. To make the picture complete, the aforesaid journal should carry the advertising of Pierce's Favorite Prescription, Hostetter's Bitters, Lydia Pinkham's Vegetable Compound, Piso's Consumption Cure and a number of other advertisements of nostrums and quackery. There is a common saying that "politics makes strange bedfellows," and we could paraphrase that by saying that a procurable income from advertising often warps the honesty and stretches the consciences of a few medical journal managers.

DEATHS

WILLIAM B. MCKINSTRY, M.D., of South Bend, died April 24th, aged fifty-eight years.

B. W. BEGLEY, M.D., of Inglefield, died April 22nd, of senility. He was seventy-two years old. Dr. Begley was graduated from the Evansville Medical College in 1877. He had been practicing medicine for forty-eight years.

WILLIAM T. BANKER, M.D., aged eighty years, died May 16th at his home in Columbus. Dr. Banker had retired from the active practice of medicine several years ago. He was graduated from the Medical College of Indiana, Indianapolis, in 1878.

A. F. PHILLIPS, M.D., of Fort Wayne, died May 3rd, aged sixty-two years. Death followed a long illness. Dr. Phillips was a member of the Indiana State Medical Association and the American Medical Association. He was graduated from the Trinity Medical College, of Toronto, in 1895.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

A CONFERENCE on rheumatic diseases was held at Bath, England, May 10 and 11, 1928.

DR. OTTO F. LEHMBERG, of Columbia City, and Miss Grace Pressler, of Albion, were married in Albion, April 26th.

THE annual dinner dance of the Indianapolis Medical Society, with the Ladies' Auxiliary, was held at the Lincoln Hotel, May 24th.

DR. C. C. DUBOIS, of Warsaw, recently underwent an operation at the Mayo Clinic, Rochester. His condition has been reported as very good.

DR. CARROLL O'ROURKE has announced the opening of offices for the practice of ophthalmology and otolaryngology in the Wayne Pharmacal building, Fort Wayne.

THE Sisters of St. Joseph's Hospital School for Nurses held graduation exercises for the seventeen members of the class of 1928 June 4th in the New Nurses' Home Auditorium.

THE Wayne County Medical Society and the Alumni Association of the Detroit College of Medicine and Surgery presented post-graduate clinics at Detroit, May 14th, 15th, 16th and 17th.

DR. EDWIN N. KIME, of Indianapolis, has been made president of the Western Association of Physical Therapy, an organization of A. M. A. members who are especially interested in that specialty.

THE Jasper-Newton County Medical Society held a meeting at Goodland April 26th, with Dr. Frank Kennedy acting as host. Dr. George Bond, of Indianapolis, presented a paper on "Diseases of the Heart."

DR. O. R. LYNCH, former superintendent of the federal hospital at Northport, Long Island, has taken charge of the Northern Indiana Hospital for the Insane at Logansport, to succeed the late Dr. Samuel Dodds.

AT the meeting of the Union District Medical Association held recently, Newcastle was chosen as the meeting place for the one hundred and twenty-second semi-annual meeting of the Association. to be held next fall.

MR. EDWARD T. THOMPSON, of St. Paul, Minnesota, has been selected as the new administrator of the Indiana University Hospitals in Indianapolis, to succeed Mr. Robert E. Neff, who has accepted a position at Iowa City.

A JOINT meeting of the Noble County Medical Society and the Noble County Tuberculosis Association was held in Kendallville, March 5th. A clinic for crippled children was conducted by Dr. L. L. Shuler, of James Whitcomb Riley Hospital, Indianapolis.

DR. C. J. BROEMAN, of Cincinnati, spoke before the Jefferson County Medical Society at the monthly meeting in Madison, April 30th. His subject was "Indications for Radium in Cancer and Skin Diseases," which was illustrated with lantern slides.

THE Northeastern Indiana Academy of Medicine held its regular meeting April 26th, in the New Lakeside Hospital at Kendallville. Wives of the doctors were guests at the banquet. A paper was presented by Dr. Charles P. Emerson, of Indianapolis.

THE annual Foundation Day Banquet of Indiana University was held at the Columbia Club, Indianapolis, Wednesday, May 2nd. There were two addresses, one by President Bryan and the other by Mr. Arkle Clark, dean of men of the University of Illinois.

THE May meeting of the Lawrence County Medical Society was held at the New Bedford Hotel, Bedford, May 2. A moving picture film was shown, stressing the importance and methods of early diagnosis of tuberculosis. Several scientific papers also were presented.

THE U. S. Civil Service Commission announces open competitive examinations for occupational therapy aide in arts and crafts, trades and industries, poultry raising, and gardening. Applications will be rated as received by the U. S. Civil Service Commission at Washington, D. C., until June 30th.

THE Ninth Councilor District Medical Society held a meeting at Lafayette, May 17th. Medical and surgical clinics were held at St. Elizabeth's Hospital and at the Home Hospital. A golf tournament was held from nine to twelve in the morning and scientific programs were presented in the afternoon and evening.

THE U. S. Civil Service Commission announces open competitive examinations for assistant medical officer, associate medical officer, medical officer, and senior medical officer. Applications will be rated as received until June 29th. Full information may be obtained from the U. S. Civil Service Commission, Washington, D. C.

THE U. S. Civil Service Commission announces open competitive examination for physiotherapy aide and physiotherapy pupil aide. Applications must be on file with the Civil Service Commission at Washington, D. C., not later than June 23rd. Full information and application blanks may be obtained from the Civil Service Commission at Washington, D. C.

THE new Lakeside Hospital at Kendallville, completed at a cost of approximately $110,000, was formally dedicated and thrown open for public inspection on Sunday, May 6th. The building was made possible through a cash donation of fifty thousand dollars by E. E. McCray, of Kendallville. The hospital is an unusually fine one and is completely modern in every respect.

THE Theta Kappa Psi medical fraternity of Indiana University initiated the following men recently: I. W. Wilkens, Indianapolis; M. E. Frantz, Liberty Center; Fred O. Clark, Terre Haute; O. F. Benz, Milltown; August J. Dian, Gary; Clarence G. Kern, Lebanon; Herman P. Schwartz, Terre Haute; H. W. Meredith, Indianapolis; Fred A. Hawk, Hammond; Paul L. Nelson, Anderson; and M. E. Hawes, Columbus.

THE Indiana University School of Medicine has announced summer courses for 1928 beginning June 14th and lasting for six weeks. Unusual clinical and laboratory facilities are available for these courses and opportunity is offered for graduate study. Complete information regarding courses offered and fees for same may be

had from the Registrar, Indiana University School of Medicine, Indianapolis, Indiana.

THE Indianapolis Medical Society held its regular weekly meeting May 7th at the Athenæum. Papers were presented by Drs. Murray N. Hadley on "End Results in the Surgical Treatment of Gall Bladder Disease;" J. A. MacDonald, on "Abscess of the Liver and Sub-diaphragmatic Abscess;" Elmer Funkhouser, on "Physiology of the Liver with Tests to Determine Function;" and Raymond Beeler, on "Cholecystography." The society held a dinner-dance on Thursday, May 24th.

THE one hundred and twenty-first semi-annual meeting of the Union District Medical Association was held at Richmond, April 26th. The program consisted of papers by Dr. P. S. Johnson, of Richmond; Dr. Webster S. Smith, of Dayton, Ohio; Dr. D. O. Kearby, of Indianapolis, and Dr. B. M. Taylor, of Portland. The association is composed of members from Butler and Preble counties in Ohio and from Fayette, Franklin, Henry, Rush, Union and Wayne counties in Indiana.

DR. E. DEW. WALES, of Indianapolis, has presented to the library of the Indiana University School of Medicine one of the most valuable gifts of books that ever has been given to the library. It consists of more than 200 volumes of German, French and English journals, as well as a number of valuable German anatomical atlases relating to the specialty of otolaryngology, and other text-books. The gift is a very valuable one and will be of great advantage to the University Library.

THE regular monthly clinic program of the Welborn Hospital Clinic was held Wednesday, May 16th, at 8:00 p. m. Dr. Walter M. Simpson, pathologist of the Miami Valley Hospital, Dayton, Ohio, and Dr. J. C. Boone, of South Bend, presented papers on "Tularemia" with lantern slide demonstration, and "The Value of Tonsillectomy in Pulmonary Tuberculosis." The meeting was attended by a large number of local physicians and also a large number of physicians from surrounding territory.

THE thirty-ninth semi-annual meeting of the Eleventh Indiana Councilor District Medical Association was held at Peru, May 17th, with headquarters at the Eagles' Home. William Jenkins, M.D., of Louisville, Kentucky, presented a clinic in the forenoon, and following a business session in the afternoon, papers were presented by Drs. William Jenkins, of Louisville; J. H. Reed, Logansport; Charles H. Good, Huntington; and Herman S. Kretschner, Chicago. Entertainment was furnished for the ladies.

THE American Association for the Study of Goiter, consisting of internists, pathologists, radiologists, etc., will hold its fifth annual conference on goiter in Denver, Colorado, June 18th, 19th and 20th. Several men from foreign countries have signified intentions of attending. Professor Breitner of the Von Eiselberg Clinic, Vienna, and Professor Albert Kocher, of Berne, Switzerland, have accepted places on the program. All members of state medical societies are invited to attend. Officers are: Dr. Gordon S. Fahrni, Winnipeg, Canada, president; Dr. K. W. Kinard, Kansas City and Dr. F. B. Dorsey, Jr., Keokuk, Iowa, secretaries, and Dr. J. R. Yung, Terre Haute, treasurer.

THE Fifth International Medical Congress for Industrial Accidents and Occupational Diseases will be held in Budapest, Hungary, September 2 to 8, 1928. Dr. Emory R. Hayhurst, of Ohio State University, Columbus, and Dr. Fred H. Albee, of New York City, both are members of the Permanent International Committee and have been appointed joint chairmen of the national committee for the United States. Dr. Richard Kovacs, of New York City, has been made secretary. The Travel Study Club of American Physicians has rearranged its summer trip for 1928 to focus upon the Budapest Congress. Correspondence regarding the congress or the trip with the Travel Study Club should be addressed to Dr. Richard Kovacs, 223 East Sixty-eighth street, New York City.

ST. MARY'S Mercy Hospital, of Gary, the pioneer hospital of Lake County, dedicated the new wing of that institution on Sunday, April 22. The new wing has been completed at a cost of $500,000 and practically doubles the bed capacity of the hospital, which now has accommodations for 265 beds. The first floor of the new wing houses the office, the library and the waiting rooms. Half of the floor space is devoted to the x-ray laboratory. The furnishings of the patients' rooms, occupying the second, third, fourth and a portion of the fifth floors, are completely modern. The new surgery on the fifth floor also is completely modern in its equipment. This unit composes four major operating rooms, two minor operating rooms and an orthopedic room. Green and ivory tile combined with marble form the walls of these rooms. The new wing of the hospital was formally opened to the public on National Hospital Day, May 12th. This hospital is operated under the direction of the Poor Handmaids of Jesus Christ.

DR. HIDEYO NOGUCHI, of New York, died of yellow fever at Akkra, on the pestilential Gold Coast of British West Africa, May 21st, while conducting researches on this disease. Dr. Noguchi was born in Japan, was educated in the

public schools of that country, and was graduated in medicine from Tokyo Imperial University in 1897. He worked in the University of Pennsylvania and in the Statens Serum Institute of Copenhagen for several years. He received the honorary degree of master of science from the University of Pennsylvania in 1906. Thereafter Dr. Noguchi accumulated honorary degrees which represented a recognition of his work wherever scientific medicine is appreciated. In 1904 he entered into an association with the Rockefeller Institute for Medical Research, passing gradually from an assistantship to a member in 1914. Since that date every research completed by him has been a contribution to the scientific progress of the world. Dr. Noguchi was especially noted for his contributions on pure cultivation of the syphilitic organism; the demonstration of the presence of syphilitic organism in the brain in general paralysis and in the spinal cord in locomotor ataxia; cultivation of micro-organisms associated with infantile paralysis and rabies; the introduction of the luetin test for syphilis; the introduction of a method for obtaining a bacteria-free vaccine for smallpox; the isolation and cultivation of the micro-organism associated with yellow fever, and simultaneously the development of a preventive vaccine and serum for use in treatment. His most recent publication dealt with an organism associated with trachoma in American Indians. Dr. Noguchi also was the author of a book on snake venoms, published in 1909; of "The Serum Diagnosis of Syphilis and Luetin Reaction," and of the "Laboratory Diagnosis of Syphilis." Death from yellow fever while he was in the course of his investigations adds Dr. Noguchi's name to the list of martyrs who have sacrificed their lives that other human beings might live free from the fear of disease.

In addition to the articles already enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

The Cheney Chemical Co.:
Ethylene-Cheney.

E. Fougera & Co.:
Lipiodol-Lafay.
Lipiodol Radiologique Descendant.
Lipiodol Radiologique Ascendant.

Mead Johnson & Co.:
Mead's Powdered Boilable Protein Milk.

Swan-Myers Co.:
Ephedrine-Swan-Myers.
Ephedrine Inhalant-Swan-Myers.

Winthrop Chemical Co., Inc.:
Phanodorn Tablets, 3 grains.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

April 16, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting of April 5th were read, corrected, and approved.

The release, "May Day—Child Health Day," read and approved for publication Saturday, April 28th.

Report received on the following medical meeting:

April 10th, Knox County Medical Society; "Genito-Pelvic Infections and Their Treatment."

Letter received from Lowell, Indiana, stating that the editor of the Lowell *Tribune* would publish weekly releases prepared by the Bureau. Instructions were given to have the Lowell *Tribune* placed upon the mailing list for these releases.

An Indianapolis pediatrician who was on the committee for the arrangement of radio programs for Child Health Week appeared before the Bureau and asked that the Bureau of Publicity be responsible for the preparation of a series of seven five-minute talks which were to be read over the radio during the week preceding Child Health Day on May 1st. The Bureau approved the plan with the understanding that no Indiana physicians' names were to be used in the articles and the name of no Indiana physician be mentioned in broadcasting the talks. The articles were to be read by a professional announcer or a physician whose name would not be announced over the radio.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole April 23, 1928.

William N. Wishard, M.D.,
Chairman.

Thos. A. Hendricks,
Secretary.

BUREAU OF PUBLICITY

April 25, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. A. MacDonald, M.D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting of April 16th were read, corrected, and approved.

The following bill was approved for payment:

A. B. Dick Company $8.00

Reports were received on the following medical meetings:

March 6th, Jackson Township, Rush County; "Diphtheria and Scarlet Fever Prevention for Children."

March 13th, Rush County, Center Township Parent-Teacher Association; "Preventive Medicine for Children."

Reports received that both meetings were very successful.

Letter received from the Director of Clinical Research, Indianapolis City Hospital, asking if it would meet the approval of the profession in general to send notices to the secretaries of the various county societies of the State Association asking them to send pernicious anemia patients to the Indianapolis City Hospital for clinical material. The proposed form letter follows:

"Since May, 1927, we have been studying the therapeutic value of liver extract in the treatment of pernicious anemia at the Indianapolis City Hospital, in cooperation with the Pernicious Anemia Committee of Harvard University. Through the kindly cooperation of the physicians of the state, we have been able to treat some sixty cases up to date, all having shown striking improvement.

"This work must be done with human patients as there is no anemia in animals comparable to pernicious anemia in man. This necessitates continuing the work with human cases, if satisfactory potent liver extract is to be obtained for the profession in general.

"If there are any available patients with pernicious anemia in your section who have not had previous treatment with liver, etc., we would appreciate very much the use of such a case to test the liver extract for potency. This would require about two or three weeks' time. We would be willing to pay the entire expense of the patient such as transportation and hospital or hotel expenses. We prefer cases which have red blood cell counts of two million or under, since it is only when the red blood cells are low that the case is of much use for clinical testing. We would consider it a pleasure to keep in touch with the physician referring the case, returning the patient to him after testing and sending all available data to him for his own use. There would be no charge to the patient. This work is being done purely for scientific purposes and is in no manner promulgated for personal gain."

The Bureau of Publicity approved of this with the understanding that it is to be done in cooperation with the Pernicious Anemia Committee of Harvard University and not in the interest of any commercial organization.

Letter received from the Antivenin Institute of America in regard to a moving picture film entitled "The Story of Antivenin." The secretary was instructed to refer this to one of the members of the Publicity Committee in order that a report may be made upon this in the near future.

The Bureau of Publicity approved a series of seven five-minute talks on children's diseases—diphtheria, immunization, etc.—that have been prepared by the Bureau of Publicity to be broadcast over Station WFBM April 30th to May 6th in observance of Child Health Week. The Bureau approved these talks with the understanding that they are to be given throughout the week by a professional announcer and that the name of no physician shall be used in connection with these talks and the credit be given simply to the Bureau of Publicity of the Indiana State Medical Association.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole May 7, 1928.

WILLIAM N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

May 7, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting of April 25th read, corrected and approved.

The release entitled "Ill Health in Your City," for publication Saturday, May 12, was read, corrected and approved.

The following bills were approved for payment:

Bailey Office Supply	$15.00
Central Press Clipping Service	5.00
	$20.00

The secretary reported that a series of five-minute talks upon "Diphtheria, Goitre, Immunization, Periodic Health Examination," etc., were broadcast over Station WFBM in connection with Child Health Week evenings of April 30th to May 5th.

Letter was received from the secretary of the Maine Medical Association thanking the Publicity Bureau for its report upon the publicity work and the work of the full-time secretary in Indiana. The secretary of the Maine Association wrote:

"I wish to thank you for your very comprehensive report. I am going through it with a great deal of interest and you have furnished me with information that will be of very great help."

The following speaking date was arranged:

May 10th, Third District Society meeting, Orleans, Indiana; "Some Clinical Manifestations of Acute Rheumatic Pericarditis."

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole May 14, 1928.

WILLIAM N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

May 14, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held May 7th read, corrected and approved.

The release, "Prevent Hay Fever Now," was read and approved for publication May 19th.

The following letter was received from a physician at Oakland City, Indiana:

"I have been informed that the Indiana State Medical Association at regular intervals sends out certain articles for general education and publicity, concerning current hygiene and health subjects, the articles where possible to be given to the general public through the local papers.

"I have talked with the city editor of our local paper and he has agreed to give some space to such topics if they seem suitable. I would like to know where I can obtain some of the articles to submit to him, and also how I can procure them in the future, if he should agree to publish them."

Secretary was instructed to send copies of several of the recent releases and also place the editor of the paper upon our mailing list.

The following bill was approved for payment:

Wm. P. Walker	$13.70

Letter was received from local officers in charge of National Child Health Week thanking the Bureau for preparing radio programs in connection with the celebration of this week. The letter says, "We are sure that these reached many hundreds of people and will bear good fruit."

There being no further business, the meeting was adjourned.

The foregoing minutes were approved in each separate part and as a whole May 21, 1928.

WILLIAM N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

INDIANAPOLIS MEDICAL SOCIETY

May 1, 1928.

The Indianapolis Medical Society held a joint meeting with the Indiana Hospital Association in the Travertine Room, Lincoln Hotel, April 10, 1928. Approximately one hundred doctors and their wives attended.

Dr. Irving S. Cutter, dean of Northwestern University School of Medicine, spoke on the "Business of Medicine and Its Relation to Hospitalization." The dinner and address was followed by dancing.

The meeting of the Indianapolis Medical Society, April 17th, was held at the Central State Hospital. The program was arranged by Dr. Max Bahr, superintendent.

The program and clinics were given by the staff of the hospital. Music was furnished by the hospital orchestra. There were pathological and occupational therapy exhibits and a good lunch was served after the scientific program. The attendance was one hundred.

PROGRAM

Dr. W. L. Bruetsch—"Extra-Pyramidal System," with lantern slides.

Dr. J. E. Kilman—Clinic showing extra-pyramidal tract lesions.

Dr. Max Bahr spoke on "Mental Mechanisms in Health and Disease."

As on previous occasions when Dr. Bahr has entertained the society, the exhibits and program reflected very creditably the high quality of medical work being done in this state institution.

The meeting of the Indianapolis Medical Society for April 24th was held at the Athenæum at 8:15 p. m. One hundred twenty-five doctors were present.

Dr. Preston M. Hickey, professor of roentgenology, University of Michigan, addressed the society. His subject was "Interpretation of X-Ray Reports in Medical Cases." His talk was illustrated with lantern slides. Many doctors from other county medical societies attended. Dr. Hickey stressed the following points:

1. Adequate training of the roentgenologist.
2. A technique that will produce the very best films from which to make a reading.
3. Re-examination if the first examination is not satisfactory, in order to clear up doubtful points.
4. Consultation of the clinician, pathologist and roentgenologist.
5. More complete instruction to medical students as to what x-ray can and cannot do as an aid to diagnosis.

CHESTER A. STAYTON, M.D.,
Secretary.

May 26, 1928.

Meeting May first.

Held at Methodist Hospital, Tuesday evening, 8:15 o'clock. Attendance, 150.

Scientific program was presented by the Research Society of the hospital, Dr. H. O. Mertz presiding.

Dr. Weller—Case presentation.

(a) Volkman's contracture.

(b) Dislocation at the hip joint following infectious arthritis.

Drs. Whitehead, Hutchins, Sage and King—Presentation of cases, Hodgkins' disease. The cases presented had been treated by the injection of a filtrate made from glands removed from the patient. Results in these two cases were very satisfactory.

Drs. Echternacht and Glass—Display of x-ray films.

1. Brain tumor—cholestoma.
2. Foreign body of metallic nature within the skull.
3. Pericarditis with effusion, showing the size of the heart shadow with and without the effusion.
4. Sarcoma of the shoulder joint with extension to the humerus and metastasis in the lungs.
5. Charcot spine—involvement of the fourth and fifth lumbar vertebræ.
6. Persistent thymus—three cases.
7. Extra-uterine pregnancies.
8. Padgett's disease with involvement of the cranial bones.

Program was discussed by Drs. Stern, H. R. Allen and T. B. Noble.

Meeting May eighth.

Athenæum—Tuesday, 8:15 p. m. Attendance. 125. Dr. L. D. Carter, president of the society, presided.

Scientific Program:

Dr. Murray N. Hadley—"End Results in the Surgical Treatment of Gall-bladder Disease." He reported on one hundred cases which he had followed up after operation at the University Hospitals.

Dr. John A. MacDonald—"Abscesses of the Liver and Sub-diaphragmatic Abscess," illustrated by lantern slides.

Dr. Elmer Funkhouser—"Physiology of the Liver with Tests to Determine Function."

Dr. Raymond Beeler—"Cholecystography," illustrated by lantern slides.

May fifteenth meeting.

St. Vincent's Hospital at 8:15 p. m.; 150 doctors attended.

Dr. Brennan, president of the hospital staff, presided during the scientific program which was presented by the staff.

Program:

Dr. Arthur Guedel—"Some New Developments in Anæsthesia."

Dr. Ralph Lochry—"Spleno-myelogenous Leukæmia, Treatment by X-Ray." Case presentation. Symptoms were relieved and blood count returned to normal after two series of treatments. This lasted for six or eight months, then symptoms and increased blood count returned with very little relief following three series of high voltage radiation.

Dr. C. R. Sowder—"Clinical Types of Hypo-thyroidism."

Dr. Thos. B. Noble, Sr.—"Cancer of the Colon. Anæmia and Heredity."

Discussion by Drs. John Cunningham, Henry Leonard and Ralph Lochry.

May twenty-fourth meeting.

Lincoln Hotel. Annual dinner, dance and bridge party Attendance was 150. At this meeting, Certificates of Service were presented to the eighteen living past presidents.

May twenty-ninth meeting.

Athenæum—Tuesday evening 8:15 o'clock.

Business meeting to discuss group insurance.

C. A. STAYTON, M.D.,
Secretary.

ELEVENTH INDIANA COUNCILOR DISTRICT MEDICAL ASSOCIATION

May 2, 1928.

The Eleventh Indiana Councilor District Medical Association will hold its thirty-ninth semi-annual meeting in Eagles' Home, Peru, Thursday, May 17, 1928.

Forenoon clinic at 10:30 by Dr. William Jenkins, of Louisville, Kentucky, on cardio-vascular diseases.

Lunch, 12:00 to 1:00 *ad libitum.*

1:00 P. M.—Business and scientific program: Cardio-vascular diseases, Dr. William Jenkins, Louisville, Kentucky.

President's Address—Dr. J. H. Reed, Logansport.

Case report, actinomycosis, Dr. Charles Good, Huntington.

Genito-urinary diseases, Dr. Herman H. Kretschner, Chicago.

6:00 P. M.—Evening banquet and entertainment at Presbyterian church.

O. G. BRUBAKER, M.D.,
Secretary.

THIRD DISTRICT MEDICAL SOCIETY

The doctors of the Third District Medical Society held their spring meeting on May 10, 1928, at Orleans. About thirty doctors were in attendance, many bringing their wives along.

The program opened with a paper by Dr. G. G. Colglazier, his subject being "Some Observations on Influenza." As Dr. Colglazier could not attend, his paper was read by the secretary and was freely discussed.

Dr. W. C. Sherwood presented a paper on "Placenta Previa," which was generally discussed.

Dr. Robert M. Moore read a paper on "Some Clinical Manifestations of Acute Rheumatic Pericarditis," which also was well received and freely discussed, following

which Dr. Miller presented Dr. William M. McClarin's paper on "Unsuspected Cases of Cerebro-spinal Syphilis." Dr. McClarin was ill in bed suffering from influenza.

An excellent lunch was served by the ladies of the Methodist church, following which Dr. Leach gave an exhortation to "watch our step" in voting for legislators.

The next meeting will be held at New Albany in October.

J. R. DILLINGER,
President.
R. E. BAKER,
Secretary.

MADISON COUNTY MEDICAL SOCIETY

The regular May meeting of the Madison County Medical Society was held on Tuesday evening, May 15th, at 6:30 o'clock. The program was held at St. John's Hospital in Anderson, and the guest speaker of the evening was Dr. David Smith, associate in obstetrics in Indiana University, who spoke on the subject of the toxemias of pregnancy. Discussion was led by Drs. E. M. Conrad and Doris Meister.

The Sisters of St. John's Hospital served their annual staff dinner to the members of the society.

M. A. AUSTIN, M.D.,
Secretary.

VANDERBURGH COUNTY MEDICAL SOCIETY

The May meeting of the Vanderburgh County Medical Society was held at the Evansville Public Health Center, Tuesday, May 8th, at 8:15 p. m.

A skin clinic was conducted by Dr. Joseph Grindon, professor of dermatology, St. Louis University. A large number of patients with various types of skin lesions were presented; Dr. Grindon discussed these cases. Considerable credit for the success of the program must be given to Dr. G. B. Underwood, who arranged for the clinical material.

A large number of local physicians were present in addition to a large number from the tri-state territory.

KEITH T. MEYER, M.D.,
Secretary.

SUGGESTIVE PROGRAM FOR A COUNTY MEDICAL SOCIETY

Programs should be prepared with the interest of the greatest number in mind. The committee should be at work now for next year's program. Excellent clinicians can be had if you want them. They travel all over our country, addressing meetings, and are glad to do it. If they use their time and money to come to us and teach us, it would seem that we should be willing to accept the teaching and honor them and our local officers by our presence at the meeting. Talk up the meeting to your competitor, get him to attend and then he won't take your patients from you. People are demanding that a physician shall keep in the front row of his profession and they know when you attend a medical meeting.

There should be ten meetings a year, termed scientific meetings. Four of these should be given by out-of-the-county men. I suggest the October, November, April and May meetings be selected for those meetings. The September meeting can well be a meeting with the hospital staff or staffs or a business meeting for the good of the society. Perhaps a legal meeting can be made of it since it is just before election and the meeting of the state legislature. The December meeting is the meeting for collection of dues and election of officers. Every member should pay his dues now. A clinic or address should be given by a member of the local society. January could be spent by visiting a neighboring society or having a union meeting with the lawyers, dentists or ministers. Same may be said regarding the February meeting. March should find a local man or men presenting an interesting clinical meeting taking up the necessary society business at this meeting. June is a good time for visiting societies a distance away. Perhaps a local physician should present an address at the regular meeting and a visit made by the society in addition to this meeting. Help some struggling society by your presence or if they are not struggling, they will be gladder still to see you.

Every physician should have an annual physical examination, should pledge himself to have a definite number of patients, say two to five, have the said examination, thus educating the people to its value and aid in putting this across.

Social Meetings: Consist in meetings during the year with other professions. An open meeting with a dinner, our wives as guests, and a non-medical man as speaker or some other entertainment. Here our woman's auxiliary can function by presenting the music, the minstrel show or some other entertainment. We must have the auxiliary and we must give them something definite to do.

Annual Picnic: In July or August with our families and perhaps some other profession as guests. This is very valuable.

Scientific Teams: Two to four members should prepare to give a program before other medical societies, thus letting them know what we have and invite them in turn to visit us. Teams must be prepared to educate the public on public health and disease: heart disease, kidney disease and the acute communicable diseases. Always seize the opportunity to speak before lunchceon clubs, high schools, parent-teachers' associations, women's clubs and various church gatherings.

Publicity: Report each meeting and all activities in a neat, concise way to the state medical journal for publication. Suppose you think you haven't had a meeting worthy of reporting, report it anyway. It may be just what some secretary is looking for to help him out. Reports should be made to the local newspaper in a clear, understandable fashion. Use language the people can interpret. They are interested in us and glad to know what we are doing. Again some members of our society learn of our doings only by the good wife reading it to them while they eat their meals.

Some things to be thinking about:

1. Is your County Medical Society incorporated? Do you think it should be?
2. Does a secretary of a County Medical Society need a committee to take notes and report items of interest to the medical journal and newspapers?
3. Do you keep a record of attendance, at meetings, of your membership?
4. What have you done for the woman's auxiliary in your county society? Do you need help? If so write Mrs. F. W. Cregor, Indianapolis, or ask some secretary in a county where the auxiliary is active. Write to the JOURNAL on the above questions.

More will be said about programs at a later date.

J. C. BURKLE, Chairman,
Committee on Secretaries' Conference.

WOMAN'S AUXILIARY NOTES

Mrs. John O. McReynolds, of Dallas, Texas, National President of the Woman's Auxiliary to the American Medical Association, was the guest of Mrs. F. W. Cregor, Saturday, May 19th. Mrs. McReynolds was enroute to Albany, New York, to address the members of the New York State Medical Association.

In April, Mrs. McReynolds spoke before a national gathering of the Young Women's Christian Association in Sacramento, California; she also presented a health film. While in the west Mrs. McReynolds was invited to appear before the officers of the California State Medical Association, and helped organize a Woman's Auxiliary in Nevada. In early May, the national president was in Chicago during the annual session of the Illinois State Medical Association, and assisted Mrs. G. Henry Mundt, the president of the Woman's Auxiliary to the Illinois Medical Association. Mrs. Ralph S. Chappell will sing a group of songs and Mrs. Cregor will play a

piano group at the luncheon party in Minneapolis when Mrs. McReynolds will be hostess to the officers and delegates of the Woman's Auxiliary.

Mrs. Ralph S. Chappell, of Indianapolis, and Mrs. Charles Combs, of Terre Haute, are delegates to the Woman's Auxiliary meetings in Minneapolis.

Mrs. F. W. Cregor will go to Rushville, Thursday, May 31, to speak before the members of the Sixth District Medical Society.

Mrs. Cregor has been appointed state chairman of the social hygiene committee of the May Wright Sewall Indiana Council of Women. It is desirable that such positions be held by wives of physicians, that they may help by their club contacts.

At the dinner dance given by the Indianapolis Medical Society, May 24th, the friendliness was marked and much of this good fellowship is the result of the meetings of the Woman's Auxiliary.

Respectfully,

MRS. F. W. CREGOR,
State President.

NINTH COUNCILOR DISTRICT MEDICAL SOCIETY

The annual meeting of the Ninth Councilor District of the Indiana State Medical Association was held at Lafayette, May 17, 1928, with a delegate representation from each of the nine counties.

Surgical operation clinics were conducted from 9:00 to 12:30 at both hospitals by Drs. E. B. Ruschle, F. S. Crockett, W. W. Washburn and A. B. Coyner. Medical clinics were attended by rather small but much interested groups.

A luncheon was held at the Lafayette Country Club, where the delegates were guests of Dr. F. S. Crockett, the county presidents were guests of Dr. W. F. McBride, and the county secretaries were guests of Dr. J. C. Burkle. We were honored by the presence of our state secretary, Mr. T. A. Hendricks, who gave us a very important and interesting talk regarding the state affairs. A survey of the candidates for the state legislature was given also. The secretary-treasurer gave a report of the recent meeting of the state organization of county secretaries, special emphasis being placed on all phases of the programs and organization. Mr. Hendricks spoke on this subject also. On roll call, each delegate spoke of the condition of affairs in his county. Dr. W. H. Williams gave a complete report of conditions in Boone County, where only seven members are shown. No meetings have been held. After considerable discussion and recommendations the meeting took it by consent that the councilor be chairman of a committee to arrange a program for and urge the attendance of members of other counties of the district at a meeting to be held at Lebanon on the first Tuesday evening of June. The holding of district meetings in the Eleventh and Ninth Districts on the same day will be cared for by the councilors. These dates should not conflict as they did this year.

Dr. Crockett made a fine report concerning the meaning of and the need of a woman's auxiliary to our medical organizations. He mentioned how our ladies can serve on committees in various clubs in the community, thus giving medicine the position it should have; that we as well as the physicians' wives should become better acquainted through their organization, and several other ways were mentioned whereby the auxiliary would be a help to the progress of medicine. Mrs. O. L. McCay, of Romney, has been appointed district representative, and recently attended a state meeting at Indianapolis. She gave a very interesting report at the ladies' luncheon. It is the recommendation of the state auxiliary that we all become better acquainted with the possibilities of such, and proceed to organize cautiously but surely.

The election of officers resulted as follows:

President—B. N. Lingeman, Crawfordsville.
Vice-President—J. H. Black, Lebanon.
Secretary-Treasurer—Fred R. Daugherty, Lafayette.
Councilor—F. S. Crockett, Lafayette.

Crawfordsville was selected as the meeting place for 1929.

The treasurer's report was as follows:

Total receipts	$167.75
Total expenditures	199.00
Balance due from local treasury	$ 31.25

The following officers were present at the luncheon:

Delegates—Dr. H. W. Sigmond, Montgomery County; Dr. Parker, Benton County; Dr. A. C. Holly, Fountain-Warren County; Dr. J. W. Griffith, Hamilton County; Dr. I. E. Carlyle, Clinton County; Dr. B. V. Chance, Tipton County; Dr. W. H. Williams, Boone County; Dr. F. T. Romberger, Tippecanoe County.

Secretaries—T. A. Hendricks, state secretary, Indianapolis; Dr. G. A. Collett, Montgomery County; Dr. V. L. Turley, Benton County; Dr. A. L. Spinning, Fountain-Warren County; Dr. I. E. Carlyle, Clinton County; Dr. Charles Hupe, treasurer, Tippecanoe County; Dr. J. C. Burkle, secretary, Tippecanoe County.

Presidents — Dr. B. N. Lingeman, Montgomery County; Dr. H. D. Kindall, Fountain-Warren County; Dr. J. W. Griffith, Hamilton County; Dr. F. A. Beardsley, Clinton County; Dr. H. J. Laws, Tippecanoe County.

The first hour, 1:30 to 2:30 in the afternoon, Dr. Emerson, of Indianapolis, presented a case of joint pain in a lady thirty-eight years of age. Began three weeks ago, suddenly; slowly involved various joints, being very tender over bone prominences on the elbows. History gave frequent attacks of sore throat and had influenza nine years ago. Some secretion from posterior nares. Never had pain before. Diagnosis, focal infection and maybe tonsils, ethmoids or sphenoids or the other accessory sinuses. Treatment: always begin above and eliminate foci of infection. After this give cod liver oil and use x-ray treatment, if needed, to chest. Dr. Emerson explained clearly how drainage from posterior ethmoids is down through the bronchial lymphatics, causing enlargement and giving symptoms which are chronic and difficult to remove. Always seek the cause of arthritis cases and remove it.

Dr. F. E. Senear, chief of the department of dermatology, University of Illinois Medical School, Chicago, presented the following cases: Three cases of psoriasis, bringing out clearly the different types and making a very extensive differential diagnosis Radio-therapy is used many times, but the first treatment should be arsenic and chrysarobin ointment. The etiology is possibly a monilium. Next case was one of a girl in high school with infectious eczematoid dermatitis. The differential diagnosis was carefully made and the following recommended for treatment: Five percent gentian violet, white precipitate ointment, crude coal tar ointment (which is obtainable in white color) and ultra-violet rays, but this used cautiously.

The third hour, 3:30 to 4:30, was taken by Drs. Arnett and Ikens. Dr. Arnett presented two cases of toxic goitre, the first showing the damage to the heart muscle, while the second, a younger woman coming in earlier in the case, has little if any damage to her heart muscle. This case has had a right lobe enlargement for twenty years or more and within the past two months has shown signs of toxicity. Metabolism test is sixty-four. The first case shows metabolism reading of forty-six, but more damage had been done. Dr. Arnett also showed a case of abdominal disturbance which has been difficult to diagnose. Perforating gastric ulcer was finally discovered. Dr. Ikens presented cases of fractures which were quite difficult to handle from the first, but seem to be doing nicely now. One case of osteitis fibrosum cysticum of the humerus required transplanting of a portion of the fibula to this portion of humerus. Emphasis was placed upon division of the tendo achilles in Potts' fractures. Fragments must be placed and held in proper

position if good results are to be obtained. Many cases of fracture with shock or marked swelling are much better if left to rest for some hours to days.

Dr. B. N. Lingeman, of Crawfordsville, gave a splendid paper on "Acute Otitis Media" in infants and children. He emphasized the great need of early incision of the drum membrane in these cases to prevent extension to the mastoid. Opening should be done under nitrous oxide anæsthesia. Irrigation of the ear with hot boric acid solution for from two days to two weeks is required. If the discharge continues three weeks or more, we should suspect mastoid involvement. Irrigate with ten grains of boric acid to one ounce of fifty percent alcohol. Inanition diarrhœa and other gastro-intestinal disturbances are found and we get complete cure when mastoid is opened. Some cases should be opened early even where symptoms do not point strongly to the mastoid. Early incision of the membrane and opening of mastoid in scarlet fever complications saves the ear in some cases.

The visiting ladies were entertained by the wives and friends of local physicians. Registration was made at the Fowler Hotel, and at noon they, with the local ladies, had lunchceon at the West Lafayette Country Club, the guests of the Tippecanoe County Medical Society. A drive was made for those caring to go, visiting places of interest in and near Lafayette and at three p. m. Dr. and Mrs. F. S. Crockett opened their beautiful home on Littleton street to them, giving a tea from three to five. At six-fifteen the ladies joined the physicians at the Home Economics Building at Purdue and enjoyed a delicious meal which is always evident when served by the home economics department at Purdue. One hundred twenty-four were at the banquet. During the serving music was furnished by Miss H. Elizabeth Burkle on the marimbaphone, accompanied by Mrs. Helen Faust Smith. Golf prizes were awarded during the banquet. First prize went to Dr. Geo. A. Collett, of Crawfordsville; second prize to Dr. B. N. Lingeman, also of Crawfordsville.

At 7:20 p. m. Prof. H. E. Enders, of Purdue, began giving his series of pictures and illustrated lecture on his recent visits to South America. Everyone enjoyed this very much. Moving pictures were also used.

At eight-fifteen Dr. Chas. P. Emerson was introduced to a good-sized audience in the Auditorium. This was a public meeting and Dr. Emerson took as his subject "Mental Hygiene." For two years Dr. Emerson has been chairman of the National Committee on Mental Hygiene and spoke authoritatively and in a very pleasing manner upon this most important subject. Special emphasis was placed on prevention of mental disease and the difficulty in curing some of them.

The following were dealt with: Neurasthenia, phychasthenia, hysteria as contrasted to hysterical, and some of the common insanities. This subject, says Dr. Emerson, is the next step in medicine.

Respectfully,

J. C. BURKLE, M.D.,
Secretary.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books received since May 1, 1928:

PRINCIPLES AND PRACTICE OF OBSTETRICS. By Joseph B. DeLee, A.M., M.D., Professor of Obstetrics, Northwestern University Medical School. Fifth edition, thoroughly revised: 1140 pages, with 1128 illustrations, 201 in colors. Philadelphia and London: W. B. Saunders Company, 1928. Cloth. Price $12.00.

TEXTBOOK OF GENERAL BACTERIOLOGY. By Edwin O. Jordan, Ph.D., Professor of Bacteriology in the University of Chicago and in Rush Medical College. Ninth edition, thoroughly revised; 778 pages with 191 illustrations. Philedalphia and London: W. B. Saunders Company, 1928. Cloth. Price $6.00.

FOLKLORE OF THE TEETH. By Leo Kanner, M.D. 316 pages. Cloth. Price $4.00. New York: The Macmillan Company, 1928.

SURGICAL CLINICS OF NORTH AMERICA. (New York Number). Issued serially, one number every other month. Volume 8, Number 2, April, 1928; 256 pages with 90 illustrations. Per clinic year (Feb. 1928 to Dec. 1928). Paper, $12.00; cloth, $16.00. Philadelphia and London: W. B. Saunders Company, 1928.

THE NEW YORK ACADEMY OF MEDICINE LECTURES ON MEDICINE AND SURGERY. (First series, 1927); 319 pages with 39 illustrations. Paul B. Hoeber, Inc., New York, 1928. Cloth. Price $5.00.

GONOCOCCAL URETHRITIS IN THE MALE. By P. S. Pelouze, M.D., Associate in Urology and Assistant Genito-Urinary Surgeon at the University of Pennsylvania; 357 pages, illustrated. Cloth, $5.00. W. B. Saunders Company, Philadelphia and London, 1928.

THE ULTRA-VIOLET RAYS. Action on internal and nervous diseases and use in preventing loss of color and falling of the hair. By Arnold Lorand, M.D. (Vienna), physician at the Carlsbad Springs, Czecho-Slovakia; 258 pages. Cloth. Price $2.50. F. A. Davis Company, Philadelphia, 1928.

ABSTRACTS

END-RESULTS FROM SURGICAL TREATMENT OF HYPERTHYROIDISM

Charles H. Frazier and W. Blair Mosser, Philadelphia (*Journal A. M. A.*, March 3, 1928), consider the end-results of the surgical treatment of hyperthyroidism. The study is based on a recent series of 146 cases which have been thoroughly followed. This group is composed of 100 hyperplastic toxic cases and forty-six toxic adenomas. In the hyperplastic toxic group the incidence of males to females was 1:4; the average age was 36 years (the youngest being 16 and the oldest 60 years), and the average duration of symptoms was sixteen months. In the toxic adenoma group the sex incidence was 1:15; the average age was 43 years (the youngest being 21 years and the oldest 67 years); the average duration of the goiter was fourteen and one-half years, and the average duration of toxic symptoms was twenty months. In group 1, the patients have been completely restored to their usual health, are engaged in their usual occupations, and, when examined, fail to show any residual effects of the disease. This group contains 75 percent of the cases. Group 2, comprising patients with mild residual symptoms, contains twenty-three patients, or 15.8 percent of the entire number. Certain systems of the body will not completely readjust themselves after removal of the cause, and it is of course probable that certain as yet unexplained organic changes have occurred in these patients that make complete restoration impossible. In the present series, the number in this group has been augmented to some extent by a few patients who are receiving a permanent disability allowance from the United States Veterans' Bureau. Group 3 contains those patients who have been relieved of the hyperthyroidism but who are definitely and permanently handicapped. It contains eight patients who, before operation, have shown signs of marked visceral injury and includes those with organic cardiac damage. The disability in six of these patients is due to cardiac injury; postoperative hypothyroidism is responsible for disability in one and mild tetany in another. In the latter patient, parathyroid injury was unavoidable. Relief of hyperthyroidism in this group and the arrest of visceral degeneration constitute a satisfactory result. Rehabilitation is not expected. Patients in this apparently permanently handicapped group often improve to such an extent that they finally enter groups 2 or 1. Groups 4 and 5 comprise the patients with definite recurrences. They are listed as operative failures, although it is known that reoperation removes them from this group. However,

as far as the initial therapeutic procedure is concerned, they have not been cured and are so listed. The series includes five cases (3.4 percent) in which there have been definite recurrences. The duration of hyperthyroidism has an effect on the operative result. The average duration of thyrotoxicosis in the patients in group 1 was sixteen months and that of the patients in groups 2 and 3, twenty months. Permanent disability has not occurred in any patient in whom the duration of the disease was three months or less. The authors conclude that operative treatment of hyperthyroidism offers a chance for recovery from thyrotoxicosis in about 96 percent of cases. Complete restitution can be expected in 75 percent of cases. About 15 percent will have mild residual symptoms. About 5 percent will be permanently handicapped. About 3 or 4 percent will have recurrences. The degree of disability is proportional to the duration of the disease. Early operation will prevent the occurrence of permanent disability.

EARLIER DIAGNOSIS OF MEASLES

Philip Moen Stimson, New York (*Journal A. M. A.*, March 3, 1928), discusses the earlier diagnosis of measles. From exposure to the onset of the first symptom of the disease—usually fever—is the period of incubation. This averages fairly close to ten days, with only rare cases falling outside the seven to fourteen day or second week limit. The duration varies with the virulence of the organism and the resistance of the patient, the more severe cases usually showing the shorter incubation periods. The blood may early show a slight leukocytosis lasting to the middle of the period of incubation, and followed by a more definite lymphocytic leukopenia toward the end of this period. In general, the features of the period of invasion may be readily enumerated chronologically by associating them with the fingers of the outspread hand. Beginning with the little finger is the first symptom, fever. Twelve hours later comes the ring finger, or puffiness of the lower eyelid and perhaps the measles line, together with the first sign of the enanthem or rash on the fauces. Twelve hours later, or middle finger, come the evidences of catarrh, also known as the three C's; to-wit, conjunctivitis, coryza and cough. Twelve hours later, or the forefinger, are found Koplik's spots. Thirty-six hours later, or as far from the forefinger to the thumb as it is from the little finger to the forefinger, comes the rash or exanthem, and for the palm of the hand we have a certain amount of headache and a considerable malaise throughout this period. A fairly definite line of congestion across each lower lid, about at the margin of the tarsal cartilage and perhaps a third of the way from the lid margin to the fornix may accompany the puffiness of the lower eyelids. This so-called measles line must be quite marked to be suggestive. It is best seen for the first time in a child in whose case there is a history of a known exposure to the disease some ten days before the day of examination and who has that day or the day before shown the first slight elevation of temperature above normal. Its duration as a line is quite brief as a rule, the injection spreading in a day or so to involve the entire peripheral conjunctiva and later the palpebral conjunctiva also. When this line has been obscured by the more general conjunctivitis, puffiness of the lids becomes marked and there is usually a seropurulent exudation with considerable photophobia. The caruncle at the inner corner of the eye becomes swollen, and occasionally there can be found thereon two or three tiny elevated bluish white spots, possibly similar in nature to the buccal spots, popularized by Koplik. Occasionally there may be found, particularly on the chest and neck, a prodromal eruption occurring during the first day or two of the fever. About the second day of fever, the enanthem appears on the soft palate, the uvula, the tonsils or the posterior pharyngeal wall. This enanthem usually lasts until the eruption on the skin is well marked, and it fades as the fever in uncomplicated cases returns to normal. Profuse involvement of the pharynx may be accompanied by pain, especially on swallowing. There next appear in the average case the clinical manifestations of catarrh. Koplik's spots comprise the first pathognomonic sign of measles. When marked, these spots resemble grains of white pepper loosely sprinkled on a red background. They first appear, usually on the second or third day of the disease, as small red patches in the center of which is a tiny opalescent whitish speck, much smaller than a pinhead. They are usually first found in the mucous membrane on the inside of the cheek about opposite the first molar teeth, but as they become more numerous they may be found all over the inside of the cheeks and in marked cases on the mucous membranes of the gums and lips. They have also been reported in nasal and vaginal mucous membranes as well as on the inner caruncle of the eye. When marked, they are usually seen in any light, and the patient may speak of the mucous membrane of the cheek as feeling rough to the tongue. When few or fading or just appearing they are best seen in strong daylight, and occasionally cannot be seen at all by artificial light. Koplik's spots usually disappear as the exanthem appears, and are found when looked for in about 90 percent of cases of measles. Koplik's spots are of especial importance because when they have been found a definite diagnosis of measles can be made and the child isolated possibly two or three days before the appearance of the rash makes the disease self-evident. The day of the appearance of the exanthem or rash should be considered at least the fourth day of the case of measles, and exposure to others should be dated from the third day prior thereto. The author makes a plea for the individual isolation of every person with measles. Measles, by itself, very rarely kills or cripples. It is the complications which are due to secondary infections that cause the deaths in almost every instance.

CASE OF INSULIN EDEMA

Aaron Leifer, Brooklyn (*Journal A. M. A.*, Feb. 25, 1928), relates the case of a man who had diabetes and who developed a severe edema following the administration of insulin. Twenty-five units of insulin was given the first day. The next day, June 16, the patient already felt much better, and was given 30 units of insulin. June 17, 18, 19 and 20, he received 30 units of insulin daily but continued to have four plus dextrose in the urine and high blood dextrose, although he felt much better. His weight had already climbed to 141 pounds (64 Kg.). He was receiving a diet containing 750 calories at this time. No edema was visible. The carbohydrate in the diet was increased in greater proportion than was the protein or fat. June 21, 22 and 23, the patient received 50 units of insulin daily; on the 22d, pitting edema of the legs was first observed. The patient felt so well now that he insisted on going back to work but was not permitted to do so. The urine for the first time on the 24th contained no acetone, diacetic or betaoxybutyric acids, and only a trace of dextrose. On the 25th, his weight was 151 pounds (68.5 Kg.) and there was definite edema of the lower extremities. The final intake was very slightly reduced but the salt intake was markedly reduced. Within ten days his weight came down to 139 pounds (63 Kg.) although his diet was gradually increased, and 40 units of insulin was being given daily. He has remained sugar free, feeling well and weighing between 137 and 140 pounds (62 and 63.5 Kg.). The edema is gone.

POSTVACCINATION TETANUS AND ITS PREVENTION

Charles Armstrong, Washington, D. C. (*Journal A. M. A.*, March 10, 1928), points out that epidemiologic evidence indicates that large insertions and the use of shields and dressings predispose to postvaccination tetanus in man. Shields and dressings markedly favor the development of postvaccination tetanus in monkeys and rabbits vaccinated with a virus artificially contaminated with *B. tetani*. A proper vaccination is defined as one in which the insertion is not more than one-eighth inch in its greatest diameter and which is made by some method that does not remove or destroy the epidermis. Such in-

sertions, when treated openly, have never, as far as the author is aware, been followed by postvaccination tetanus.

INTENSIVE POSTURAL REST IN TREATMENT OF PULMONARY TUBERCULOSIS

W. A. Gekler and B. J. Weigel, Albuquerque, N. M. (*Journal A. M. A.*, Feb. 25, 1928), believe that in intensive postural rest as they use it they have a method of treatment of pulmonary phthisis that deserves to rank with artificial pneumothorax and thoracoplasty in value and effectiveness. It is applicable in a wider range of cases. Complications are no more frequent and certainly less dangerous than with pneumothorax or thoracoplasty. When results are not obtained, pneumothorax or thoracoplasty may still be used. They see striking benefits, *i. e.*, the maximum amount of healing possible in view of the nature and extent of the lesion, in fully one-fourth of their cases, and in another fourth there is considerable improvement. When clinical cures are obtained with postural rest, they are just as enduring as with any other form of treatment.

HEMATURIA DUE TO SHOE DYE POISONING

One case of hematuria due to shoe dye poisoning is reported by Henry H. Haft, Syracuse, New York (*Journal A. M. A.*, March 10, 1928). The patient was a youth, aged 19, strong and athletically inclined, with a negative past history, and with a marked cyanosis. He had put on a pair of shoes which had been dyed black that morning. An hour later he complained of some nausea, felt light-headed and became very irritable. His lips and ears were blue, which state increased during the afternoon to a real cyanosis. The heart sounds were somewhat feeble. There was no arrhythmia, and the blood pressure was 95 systolic and 55 diastolic. The pulse rate was 90. The temperature was normal. The hemoglobin was 100 +. The red blood corpuscles numbered 6,200,000; the white corpuscles, 7,500, with a normal differential count. The non-protein nitrogen was 40 mg. per hundred cubic centimeters. Venipuncture produced blood which was unsually dark. The urine was essentially normal with the exception of its dark brown color. Microscopic examination did not reveal any formed elements. The patient was put to bed; his feet were washed with a dilute alcoholic solution, and elimination treatment was started. The following day he complained of great frequency with dysuria, and the urine became very bloody. Discomfort associated with urination increased and blood clots appeared in the urine. Microscopic examination did not show any renal casts or epitheliums, but the specimens were loaded with red blood cells. This hematuria kept up for four days and then gradually diminished in intensity. At the end of the second week there were still many red blood cells in the urine, but blood was not detected macroscopically. At the end of the third week only isolated red blood cells were to be seen. At no time was the output diminished. The blood pressure remained low and there was no edema. The non-protein nitrogen remained at the level first found, 40 mg. per hundred cubic centimeters. The cyanosis disappeared after the first day, and, subjectively, with the exception of urinary discomfort, the patient felt much better after the first twenty-four hours.

MODE OF CLOSURE AND DRESSING OF WOUNDS, ESPECIALLY THOSE OF HEAD

Walter Rogers Brewster, New Orleans (*Journal A. M. A.*, March 3, 1928), reports a successful method of bandaging and dressing of head wounds. He describes the dressing and its application in an account of a man who was struck on the head by a steel plate. The wound extended through the periosteum, exposing the bone and freeing the insertion of the temporal muscle. In closing, the periosteum was sutured, and the insertion of the muscle replaced with absorbable material, several silkworm sutures being used to approximate the wound edges, which were then brought together accurately with large Michel clips. Under the arch formed when these clips are bent in place, an open sponge is passed by means of a probe. It is then spread between the clips to cover the wound, the ends cut smooth, and the dressing is complete. Moreover, it will not move unless the clips are pulled out of place, and this procedure is painful and difficult enough to deter the patient from attempting it. The slight serous oozing from the wound is absorbed by the gauze and dries, and the wound is entirely sealed. From the fifth to the seventh day, the dressing is removed by straightening the clips in the usual way. The gauze will be found to be stuck, and may be left to fall off or be soaked off by the patient. The sutures, if any have been used, are are removed in the customary manner. Any infection or swelling may be easily seen and readily dealt with, since the dressing covers only the wound itself, leaving the surrounding area exposed. Any part of it may be removed by cutting out the desired section of gauze and by removing the clip.

COUNCIL PASSED

The notable success of many pharmaceutical products which have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion in "New and Nonofficial Remedies" recommends not only the plan itself, but the wisdom of the medical profession in selecting these reliable "Council Passed" remedies for daily use.

Among the medicinal chemicals now being widely used are such "Council Passed" products as Ephedrine Hydrochloride, Neocinchophen, Butyn, Metaphen, Butesin Picrate, Anesthesin, Chlorazene, Amidopyrine, Procaine and Neutral Acriflavine, all of which are described in the recent edition of "New and Nonofficial Remedies."

These remedies are the result of research and clinical study. They have been announced in our pages and are worthy of further investigation on the part of our readers.

DIPHTHERIA PROPHYLAXIS AMONG ASTHMATIC PATIENTS

Six asthmatic children who were free from asthmatic symptoms for several months had recurrences of attacks coincidentally with the administration of toxin-antitoxin. In two other children with an allergic family history, the first asthmatic attacks were brought on by toxin-antitoxin administration. The attacks were of very severe type. They were not as easily controlled as ordinarily. The skin tests for horse serum were found positive. In all cases eosinophilia was present; in seven of them the eosinophilia ranged higher after the injections than before. George L. Waldbott, Detroit (*Journal A. M. A.*, Jan. 28, 1928), suggests that it may be possible, by giving small desensitizing doses of serum, to prevent untoward symptoms from diphtheria prophylaxis in allergic patients.

REPORT OF THE COMMITTEE ON RADIOLOGICAL FRAUDS AND IMPROPER PRACTICES*

Some of the remarks made by counselors from various parts of the country seem to indicate that this specialty is threatened by dangers which are more or less peculiar to radiology. It seems that in different parts of the country fee-splitting, masquerading under various disguises, is becoming rather prevalent. If one were to attempt to find the source of these various tendencies and to classify them, he would give first place to the organizations, corporations, or companies selling stock to physicians and surgeons and encouraging these men to refer their cases to x-ray laboratories operated and owned by such corporations or companies, in the hope of receiving dividends upon their stock; and, of course, the more cases referred, the larger the dividends. The plan constitutes, stripped

*Read at the 13th Annual Meeting of the Radiological Society of North America, at New Orleans, November 28 to December 2, 1927.

of its business terminology, nothing more nor less than an offer of a financial inducement to physicians to refer their cases to certain x-ray laboratories. Then we have another type of organization which is rather innocent on its face but which offers discounts to members of the organization. That is to say, if the member refers his cases to the laboratory in which he is financially interested, he may have charges for x-ray services made to himself, and then he may take a discount of twenty or twenty-five percent or more and collect the full fee from the patient. As a matter of fact, there is no restriction whatever to the fees this man may charge; he may obtain his x-ray services on a small-fee basis, and then take his discount and charge his patients a large fee for the same service. This creates a rather dangerous situation. Some of these laboratories which operate as stock companies are operating without a roentgenologist in charge, the members themselves claiming they are quite competent to make their own interpretations, their own fluoroscopic observations, and to prescribe treatment. Some of them employ a physician as a figurehead, who is supposed to pass upon cases coming to the clinic, but he actually does not. The diagnosis is made by the technician and the physician's name is signed to the report.

Now, in order to bring this matter before the Society and try to get something concrete done we have prepared a set of resolutions upon which we ask your approval. The question will arise, of course, in all of your minds, as to what good this may accomplish. It seems to your committee that, if it does nothing more, it will place us on record with a certain definition of commercial x-ray laboratories and unethical x-ray laboratories; it will define clearly what we regard as ethical practice and as unethical practice. With that backing, we can go before our own local medical societies to obtain their support in cleaning up this situation in various localities throughout the United States. Here are the resolutions which we have to present:

WHEREAS: Certain practices are becoming prevalent in various parts of the United States, which threaten the welfare of radiology, affecting the practice of this branch of medical science in a peculiar, deleterious, and harmful manner, and

WHEREAS: It is an important function of any medical organization to protect its specialty from the harmful effects of improper, unethical, or dishonest practices,

BE IT RESOLVED: By the Radiological Society of North America, in executive session at its thirteenth annual meeting, that: (1) Radiological diagnosis is a consulting specialty of medicine, the chief function of which is to aid practitioners of other specialties and of general medicine in the diagnosis and treatment of disease; (2) that it is improper and unethical for any radiologist or any organization practicing radiology to offer discounts or commissions, or other financial inducements, to attract patients either directly or through reference by other physicians; (3) that it is unethical for any radiologist or organization practicing radiology to make charges to referring physicians for services rendered, but that all such charges must be made against the patient for whom such services are rendered; (4) that a commercial x-ray laboratory is defined as one which advertises to make radiographic or fluoroscopic examinations for physicians and surgeons for the avowed or apparent primary purpose of financial gain; (5) that it is improper and unethical for any radiologist to become affiliated with a commercial x-ray laboratory; (6) that a stock company or corporation with physicians and surgeons as stockholders, offering dividends as an inducement to refer cases to a laboratory owned and operated by such company or corporation, is unethical, and that such dividends be regarded in the same light as commissions or discounts. A group of physicians may properly own and operate an x-ray department or laboratory, providing the earnings therefrom are employed for the advancement of the science of radiology or other branches of medicine or the maintenance and improvement of service to patients, but not as an inducement to stockholders to refer cases in the hope of receiving greater dividends.

RESOLVED: (7) That an x-ray laboratory is to be considered unethical if therefrom emanate diagnostic reports based upon the radiologic observations of technicians who do not possess a medical degree or license to practice medicine.

The mere signature of a physician to such reports is to be regarded as an evasion of this rule unless such signatory has actually made the observations and drawn the conclusions upon which such reports are based.

BE IT FURTHER RESOLVED: (1) That no radiologist engaging in unethical practice according to the above definition shall be eligible to membership in this society, and that no technician affiliated with an unethical or commercial laboratory shall be eligible to registration; (2) that a copy of these resolutions be forwarded to each state medical society with a request that they be published in the official journal; (3) that a committee be appointed to obtain the official approval of these resolutions by the American College of Radiology, the American College of Surgeons, and the American College of Physicians.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

POLLEN EXTRACTS - HOLLISTER - STIER.—Liquids obtained by extracting the dried pollen of plants with a liquid consisting of forty-eight percent of glycerin, five percent of sodium chloride and forty-seven percent distilled water. For a discussion of the actions, uses and dosage see Allergic Protein Preparations, New and Nonofficial Remedies, 1928, p. 23. Pollen extracts- Hollister-Stier are marketed in treatment sets of five vials and in treatment sets of thirty vials, representing graduated concentrations. The following preparations have been accepted: Alder Pollen Extract-Hollister-Stier; Aspen Pollen Extract-Hollister-Stier; Atriplex Pollen Extract-Hollister-Stier; Awnless Brome Grass Pollen Extract-Hollister-Stier; Blue Bunch Grass Pollen Extract-Hollister-Stier; Box Elder Pollen Extract-Hollister-Stier; Canada Blue Grass Pollen Extract-Hollister-Stier; Cheat Pollen Extract-Hollister-Stier; Common Sagebrush Pollen Extract-Hollister-Stier; Crested Koeleria Pollen Extract-Hollister-Stier; Dandelion Pollen Extract-Hollister-Stier; Eastern Ragweed Pollen Extract-Hollister-Stier; English Plantain Pollen Extract-Hollister-Stier; Giant Poverty Weed Pollen Extract-Hollister-Stier; Kentucky Blue Grass Pollen Extract-Hollister-Stier; Lamb's Quarters Pollen Extract-Hollister-Stier; Mugwort Pollen Extract-Hollister-Stier; Orchard Grass Pollen Extract-Hollister-Stier; Perennial Rye Grass Pollen Extract-Hollister-Stier; Quack Grass Pollen Extract-Hollister-Stier; Red Top Pollen Extract-Hollister-Stier; Redroot Pigweed Pollen Extract-Hollister-Stier; Russian Thistle Pollen Extract-Hollister-Stier; Sandberg's June Grass Pollen Extract-Hollister-Stier; Sheep Sorrel Pollen Extract-Hollister-Stier; Spring Birch Pollen Extract-Hollister-Stier; Timothy Pollen Extract-Hollister-Stier; Velvet Grass Pollen Extract-Hollister-Stier; Western Ragweed Pollen Extract-Hollister-Stier; Willow Pollen Extract - Hollister - Stier. Hollister-Stier Laboratories, Spokane, Washington. (*Jour. A. M. A.*, April 7, 1928, p. 1116).

B. ACIDOPHILUS MILK-ADOHR.—A milk culture of *B. acidophilus* which contains not less than 250 millions of viable organisms (*B. acidophilus*) per cc. at the time of sale. For a discussion of the actions and uses of bacillus acidophilus preparations see Lactic Acid-Producing Organisms and Preparations, New and Nonofficial Remedies, 1928, p. 228. Laboratory Division of the Adohr Creamery Co., Los Angeles, California.

PHANODORN TABLETS, 3 GRAINS.—Each tablet contains three grains of phanodorn (New and Nonofficial

Remedies, 1928, p. 96). Winthrop Chemical Co., Inc., New York.

SOLUTION EPHEDRINE SULPHATE-P. D. & CO., 3 PERCENT.—A three-percent solution of ephedrine sulphate-P. D. & Co. (New and Nonofficial Remedies, 1928, p. 178). Parke Davis & Co., Detroit. (*Jour. A. M. A.*, April 21, 1928, p. 1291).

EPHEDRINE-SWAN-MYERS.—A brand of ephedrine-N. N. R. (New and Nonofficial Remedies, 1928, p. 174). It is also supplied in the form of Ephedrine Inhalant-Swan-Myers, a one-percent solution of ephedrine in light liquid petrolatum. (*Jour. A. M. A.*, April 28, 1928, p. 1377).

PROPAGANDA FOR REFORM

CLAUDEN NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that Clauden, manufactured by Luitpold-Werk, Munich, Germany (East Brook, Inc., New York, distributor), is claimed to be a harmless, efficient and superior hemostatic for local, oral, hypodermic and intravenous administration. On the basis of the evidence presented by the manufacturer and distributor, the Council found Clauden unacceptable for New and Nonofficial Remedies because its potency and keeping qualities are not controlled; because the labels and advertising contain no caution of the possibility of anaphylactic reaction from foreign protein; and because the claims advanced for it are unwarranted.—(*Jour. A. M. A.*, April 7, 1928, p. 1116).

KALZAN NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that Kalzan is the name applied to a double salt of calcium and sodium lactate manufactured by Johann A. Wulfing, Chemical Works, Berlin (The Wulfing Co., Inc., New York, distributor). The product is claimed to have none of the irritating properties of calcium chloride and to possess the advantage of being more readily retained in the tissues than ordinary calcium lactate. This is claimed to be due to the presence of the sodium lactate, which is claimed to increase the alkalinity of the blood and to enhance the ability of the tissue cells to hold the absorbed lime. These claims the Council held not to be substantiated by acceptable evidence. The Council held Kalzan unacceptable for New and Nonofficial Remedies because it is an unoriginal compound marketed under a proprietary, nondescriptive name; because the therapeutic claims advanced for it are unwarranted, and because its use is irrational and unscientific in that this double salt of calcium lactate and sodium lactate is of a lesser therapeutic value than calcium lactate alone.—(*Jour. A. M. A.*, April 7 ,1928, p. 1117).

HART'S ALIMENTARY ELIXIR OF BEEF NOT ACCEPTABLE FOR N. N. R.—This product, generally referred to in the advertising as "Hart's Elixir," is stated by E. J. Hart, Ltd., to have the following composition: Total solids, 20.75 percent; total proteids (peptones, albuminoids), 2.65 percent; carbohydrates, 12.0 percent; alcohol, by volume, 19.5 percent; sodium glycerophosphate, to each fluid ounce, 6 grains; potassium glycerophosphate, to each fluid ounce, 6 grains; preservatives used, alcohol and glycerin. This preparation belongs to the class of liquid medicinal foods which the Council on Pharmacy and Chemistry has omitted from New and Nonofficial Remedies because their usefulness in present-day dietotherapy lacks substantiating evidence. It is "fortified" with glycerophosphates, which are now generally considered of little therapeutic value. It is marketed under a name which is therapeutically suggestive, with claims that are extravagant and misleading, and in a way to lead the public to depend on it for nourishment which it does not contain. The Council declared Hart's Alimentary Elixir of Beef unacceptable for New and Nonofficial Remedies.—(*Jour. A. M. A.*, April 7, 1928, p. 1117).

THE WRIGHT TUBERCULOSIS TREATMENT.—A Mrs. Carrie Wright was in the "consumption cure" business at Corinth under the names "Wright Tuberculosis Healthtorium" and "Carrie Wright T. B. Foundation." Carrie Wright was the wife of one Chas. O. Wright, who had been engaged in "consumption cure" quackery for years. The nostrum was sold under various trade names: "The Dr. C. O. Wright Co.," "Wright Ricks Drug Company," "Wright-Duering Antitoxine Company," "Wright Chemical Company" and probably others. The A. M. A. Chemical Laboratory analyzed a specimen of the "Wright's Tuberculosis Treatment" obtained from Corinth, Mississippi, and also a specimen of "Wright's Tubercular Remedy" from the Carrie Wright Foundation at Chicago. From its tests the Laboratory concluded that the first preparation is essentially a water-glycerin solution to which caramel has been added and that the second specimen appeared to be identical with the first.—(*Jour. A. M. A.*, April 7, 1928, p. 1141).

EPILEPSON.—"Epilepson," described in the advertising as an "amazing discovery" which "stops epileptic attacks at once," has been put on the market by the Epilepson Company, Inc., of Brooklyn, New York. Later the name of the concern seems to have been changed to the Remedy Products, Inc., of New York City. An examination of Epilepson in the A. M. A. Chemical Laboratory showed that it was essentially phenobarbital (luminal).—(*Jour. A. M. A.*, April 7, 1928, p. 1141).

TERPEZONE NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that according to the information of the Knox Terpezone Company, "Terpezone" is produced by passing a mixture of ozone and pinene vapor through a "combined chemo-electrical generator of a highly specialized nature." The Council further reports that "Terpezone" is claimed to be a pinene ozonide, but that the firm's positive statement in regard to the composition of "Terpezone" is not warranted. The Council reviews the evidence for the therapeutic value of treatment with "Terpezone" and finds that this is not acceptable. The Council was obliged to declare "Terpezone" unacceptable for New and Nonofficial Remedies because no satisfactory evidence is presented to show that "Terpezone" is pinene ozonide or that in the manufacture of the product the formation of injurious by-products is controlled or prevented; because the claimed harmlessness of the product is not established, and because it is marketed with unwarranted and exaggerated claims of therapeutic value.—(*Jour. A. M. A.*, April 14, 1928, p. 1197).

ORLANDO EDGAR MILLER.—Recently a Canadian paper reported that the question of deporting "Dr." Orlando Edgar Miller was being considered by the Canadian authorities. For the past few years Miller's line has been "applied psychology" and motion picture company promoting. In the early nineties, Miller was running a "rupture cure" concern. Subsequently he is reported to have exploited a "medicated sand treatment" as a "sure cure for dyspepsia." Then he organized the "St. Luke's Society," to exploit a "cure" for drug addiction. His next venture was a combination "university" and "sanitarium." Then he founded the "International Institute for the Treatment of Tuberculosis" and later transferred his activities to Europe. In 1920 Miller was back in America as the "Affirmative Apostle of Intense Individuality." He went to California in 1921 and organized a motion picture concern known as the "Rellimeo Film Syndicate." In 1925 he was reported under investigation by the grand jury of Boston as a promoter of the "Temple of Psychology." Buffalo papers then reported his arrest on the charge of grand larceny. In January, 1927, two warrants were issued against Miller, one charging embezzlement and the other charging violation of the state corporate securities law of California.—(*Jour. A. M. A.*, April 14, 1928, p. 1235).

USE OF LENS ANTIGEN IN CATARACT.—The successful cure of cases of incipient cataract by the injection of lens antigen as proposed by A. E. Davis is yet to be reported. In 1924 the Council on Pharmacy and Chemistry considered the evidence available and found it in-

(Continued on advertising page xx)

NOW
MARGINAL BLUR

CAN BE REMOVED BY THE OCULIST

OPTICAL instruments have become remarkably accurate. Oculists can and do write exceedingly precise prescriptions. Yet, for years, the oculist has realized that if the eye itself did not accommodate for slight errors in the margins of ordinary ophthalmic lenses, oblique vision actually would be blurred.

Tillyer lenses are free from marginal errors—in fact, accurate to the very edge. Furthermore, because of a better finish, Tillyer lenses give a *noticeably* cleaner, brighter definition through the center and, because of their greater accuracy, *hold this definition over the entire surface of the lens.*

We urge you, when writing lens prescriptions, to consider seriously the facts of cleaner, brighter vision through Tillyer Lenses. The greater accuracy of these lenses is vouched for by the Research Division of American Optical Company of Southbridge, Massachusetts.

Bifocal wearers make constant use of the margins of their lenses. Tillyer bifocals will greatly benefit them.

New!
Tillyer Lenses
Accurate to the very edge
Patented

TRUTH ABOUT MEDICINES

(Continued from page 276)

sufficient to permit recognition of the product. In the six years that have elapsed since lens antigen was first proposed for use in the treatment of cataracts there has been no scientific corroboration of Davis' alleged results.—(*Jour. A. M. A.*, April 14, 1928, p. 1239).

THE PHYSIOLOGIC POTENCY OF ACTIVATED STEROLS.—Experiments indicate that about twenty billionths gram of vitamin D is sufficient to produce chemical deposition in a rachitic rat. It has also been reported that ten millionths gram of irradiated ergosterol daily is sufficient to promote the healing of rickets in rachitic rats.—(*Jour. A. M. A.*, April 21, 1928, p. 1295).

ANNUAL MEETING OF THE COUNCIL ON PHARMACY AND CHEMISTRY.—Among the questions considered, those of special interest to the medical profession were: It was decided to cooperate with the Committee of Pharmacopeial Revision in studying the activity of a digitalis preparation for hypodermic use offered for the Pharmacopeia. It was decided that unless new evidence develops, to exclude all digestive enzyme preparations from New and Nonofficial Remedies with the close of 1929. It was decided to omit all desiccated pituitary preparations from New and Nonofficial Remedies with the close of the longest period for which any such preparation now stands accepted, unless before then new evidence for their value becomes available. The Council discussed the available evidence for the value and rationality of a mixture of a barbital compound, marketed as such and found acceptable, with an analgesic such as amidopyrine, provided such a mixture is marketed under a name descriptive of its composition and the claims made for it are supported by acceptable evidence. The Council voted to recommend to the Board of Trustees that the distribution of New and Nonofficial Remedies to medical classes be resumed. It was decided to ask the general manager to mark distinctively in the American Medical Directory those journals which will promise to limit their advertising of proprietary medicines to those accepted for New and Nonofficial Remedies. The Council proposes to offer its cooperation with a view to examining all food preparations (except natural foods in their natural state) proposed for advertising in A. M. A. publications. The Council considered the question of the importation of non-narcotic drugs now barred by the Narcotic Drug Import and Export Act.—(*Jour. A. M. A.*, April 28, 1928, p. 1377).

REMEDIES FOR SEASICKNESS.—It has been reported that sodium nitrite is of value in the treatment of seasickness. A support of this method comes in a report that glyceryl trinitrate—which acts as a nitrite—was found to prevent and cure seasickness.—(*Jour. A. M. A.*, April 28, 1928, p. 1381).

AL-14.—The widely advertised "patent medicine," "Formula AL-14," is marketed by the American Chemical Company of Pittsburgh, which was previously known as the Research Laboratories of Pittsburgh. The American Chemical Company has exploited three products: "RA-3," "RA-9," and "AL-14." The first was for mental exhaustion and aphrodisiac effects were ascribed to it. The second was said to be similar to RA-3 except that it was for women. AL-14 is claimed to be "an insurance against colds, flu and pneumonia." The A. M. A. Chemical Laboratory reports that a package of the preparation contained twenty-four small oiled paper envelopes. Twelve carried directions printed in red and the other twelve carried directions printed in blue; one of the envelopes contained citric acid and the other one a mixture of bicarbonates which, when added to water, effervesce, yielding a solution having as its essential constituents citrates of potassium and sodium, together with a trace of a calcium salt and a small amount of unneutralized citric acid.—(*Jour. A. M. A.*, April 28, 1928, p. 1394).

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ORIGINAL ARTICLES

LOW BACK PAIN*

F. C. KIDNER, M.D.
DETROIT

From time immemorial the human race has suffered from "lumbago", or pain in lower back. It has been ascribed to all manner of causes, and given many names. Treatment has been of every sort, and only occasionally of value. As a result, until the last twenty years, pain in the lower back was generally accepted, like other forms of "rheumatism", as a necessary evil to be borne with what complacency the sufferer could muster.

It was not until the beginning of this century that serious attempts were made to explain the pain on scientific and accurate grounds. The researches of Goldthwaite of Boston, on the sacro iliac joints and the lumbo-sacral joints, first gave a reasonable mechanical explanation for the pain. Since that time a long list of clinicians, Swain, Marshall, Freiberg, Magnuson, and many others, have studied the matter more and more intensively, and have arrived at certain fairly well defined conclusions as to the causes of low back pain. The treatment is much less thoroughly standardized.

The common causes of severe low back ache are disturbances of one sort or another in the bones or joints of the lower spine. The sacro-iliac and lateral lumbar articulations are true joints of the sliding type. Although they have very small arcs of motion under normal circumstances, they are subject to all the lesions which affect joints elsewhere in the body. Muscle lesions sometimes cause pain. Rarely do the ordinary pelvic disturbances in women cause backache. Inflammatory lesions or tumors in the pelvis may do so. Tumors of the spinal cord, malignant disease of the spine, or rectal carcinoma, all occasionally produce low backache. They do so by direct pressure on nerve trunks. They are rare, but should always be excluded carefully in the diagnosis of low back pain.

Although these other causes do exist, still in the main, the ordinary backache which we see daily is due to trouble in the joints or bones of the lower spine. The reasons for this are plain to see, and they are largely anatomical.

The lower spine is essentially weak, primarily because the sacrum in our evolution from the quadruped to the biped, has never reached the vertical position, but has remained suspended between the two sides of the pelvis, tilted sharply forward. On this tilted sacrum rests the whole weight of the trunk, and this weight is transmitted through a curved, instead of a straight, lumbar spine. This mechanically poor design leads to constant strain of the parts to prevent the body weight from sliding forward.

It is therefore apparent that the ligaments which hold the sacrum to the sides of the pelvis, and which hold the lower segments of the spine to the sacrum, must be under excessive and constant strain. To make this matter worse, the joints between the various bones of this region are of the weak flat type, that is, they have not the inherent structural strength which goes with the ball and socket joint. They are sprained or slip more easily than would the ball and socket type of joint when their ligaments and supporting muscles are relaxed. Actual dislocations of these joints, however, occur only as the result of severe injury accompanied by fracture. Subluxation may occur in very much relaxed individuals, for example, after pregnancy.

This instability of the whole lower spine and pelvis is the cause of a very great proportion of lower backaches. All varieties of sprains, strains and stresses may occur in the complicated system of joints, all of which work at mechanical disadvantage.

To make matters worse, the nerve roots which go to make up the sciatic and anterior crural system of nerves, all issue from foramina, which are in close relation with the lower lumbar lateral, the lumbo sacral lateral or sacro-iliac joints.

In the normal condition of these joints there is sufficient room for the nerve roots with their sheaths, but any small amount of swelling in these joints may constrict the nerve roots or actually press on the nerve trunks, with resultant pain referred to the region supplied by the nerve pressed on.

This close relationship between the nerve roots and the articulations of the lower spine, explains

*Presented before the Muncie Academy of Medicine, October, 1927.

the close association in the minds of the public of "lumbago and sciatica."

All the joints entering into the lower spine are subject to the same maladies that joints elsewhere are, and may be strained, sprained or infected, and inter-articular fractures may occur.

Anatomic variations are common in this region. These, although not in themselves causes of backache, do frequently make the mechanics of the system of levers weaker, and thus increase the liability to sprain.

Fortunately the voluntary muscular support of the spine is very powerful, and when it is not weakened by disease, or general muscular relaxation, serves as a most efficient protection against injury.

We have mentioned various possible causes of backache, such as pelvic disease, tumor, etc., but from this point on we shall assume that we are discussing only backache due to trouble in the bones, joints and muscles of the lower spine.

These troubles are as follows:

1. Acute trauma.
2. Recurrent trauma.
3. Arthritis.
4. Malignant disease.
5. Anatomical variations.
6. Muscular lesions.

Acute trauma may cause fracture of the bones, or sprain or strain of the joints. The two commonest causes of acute injury are falls and the lifting of heavy weights.

The amount of injury may range from a compression fracture of the body of a vertebra, through fractures of the lateral articulations or lateral processes, to sprains and strains of the joints themselves.

The symptoms do not vary with the degree of the severity of the injury. That is, a man with a compression fracture of his fourth lumbar vertebra, or with a fracture of the transverse process, may not have as acute pain and severe disability as a man who has merely sprained the sacro iliac joint. This is because the pressure of the swelling around the fracture may be cushioned by muscle tissue, whereas the swelling around the sprained joint brings severe pressure to bear upon ligaments and overlying nerves. Of course, the symptoms from the fracture persist very much longer than do those from the sprain.

A differential diagnosis of the acute injuries of the lower spine is difficult. It depends upon careful study of the location of the pain, of the location of tenderness, on the presence or absence of referred pain, on the position and amount of muscle spasm, and on the amount of disability. For instance, an acute sacro iliac sprain is usually easy to recognize by the presence of tenderness over the joint, by the presence of marked spasm of the lumbar muscles on the side affected, by limitation of motion of the back in all directions, by marked limitation of flexion of the thigh with the knee straight. Often there are added to the above symptoms a list of the spine toward the affected side, and pain referred down the whole course of the sciatic nerve on that side. This pain is due to the pressure on the nerve trunks of the sciatic by swelling around the sprained joint. Usually, also the pain is paroxysmal in character and agonizing when any effort is made which causes movement in the affected side.

An injury to a lumbo-sacral lateral articulation is usually recognized by sensitiveness on deep pressure over the injured joint, by pain referred to the same area, by muscle spasm of the lumbar region, usually on both sides, by limitation of motion of the spine, especially toward the affected side, and by the absence of limitation of flexion of the thigh with the knee straight. In these cases when there is referred pain down the course of the sciatic, it is usually localized in the area supplied by the particular branches which are in contact with the injured joint, rather than in the whole sciatic. The fracture of one of these joints usually produces more severe symptoms than the simple sprains, but the symptoms are of much the same type. An x-ray, of course, demonstrates fractures, but does not demonstrate sprains. In diagnosing all acute injuries of the lower spine, a good x-ray picture, both in the lateral and anteroposterior directions is absolutely essential.

The treatment of these acute injuries is primarily rest. This rest should be in bed and the bed should be firm so that the body cannot sag. Boards placed between the frame of the bed and the springs, satisfactorily prevents this sagging. The patient should be kept upon his back in so far as it is possible, and there should be a folded sheet under the lumbar spine to preserve the normal lumbar lordosis, and thereby take strain off the damaged tissues. Heat should be freely used, best in the form of the electric pad. Adhesive plaster strapping firmly applied across the lower lumbar and sacral regions, from trochanter to trochanter, acts as a splint, and is usually a great comfort to the patient.

The acute sprains recover promptly under such treatment in from three to four days to two weeks. The patient should not be let out of bed until the pain has entirely disappeared.

Fractures require much longer periods of rest. It is usually best to treat these at first in a molded plaster of Paris splint, in which the patient lies as in a trough. This gives more complete fixation than the strapping. A fracture of the lateral process should have four weeks in recumbency, followed by a plaster of Paris jacket for four to six weeks longer. A fracture of the lateral articulations requires about the same amount of time. A compression fracture of the body of the lower lumbar vertebras, although rare, is an extremely serious matter, as it is elsewhere in the spine. The soft cancellous bone of the vertebral

bodies is very slow to repair. Industrial surgeons everywhere have learned this to their cost. I believe compression fractures of the vertebral body should be kept in bed in a plaster of Paris shell for at least three months and wear a jacket for at least six months longer. This is the minimum of treatment. The average results would be much better if all the cases were immediately operated upon by the Hibbs method, and the spine fixed. Unfortunately it is impossible to persuade many patients to allow this form of treatment.

Insurance companies have learned to their cost that if these cases are not treated correctly over very long periods, that complete permanent disability is very frequently the result. Even under the best of treatment it is unusual for one of these compression fractures to get back to work in less than a year.

Recurrent Trauma

The ligaments of the joints of the lower spine are, under normal conditions, so well supported by the powerful muscles of the lower back, that they can be damaged only by severe acute injury. If, however, for any reason, these powerful muscles are thrown off their guard, then the brunt of the work of supporting the body comes directly on the ligaments of the joints. The muscles fail in their function for various reasons. First and most frequently because they are overtired, as for instance, by work too strenuous for the strength of the individual, by working in strained positions, by constant assumption of bad posture and by debilitating illnesses.

As in other regions of the body when the muscle support of the joints becomes weakened, then the non-elastic ligaments gradually stretch, and relaxed joints are the result. This is frequently seen in the ordinary cases of weak feet, where flat foot is produced through failure of the adductor muscles of the foot. Relaxed joints are sore and painful joints, and this is the condition essentially found in backs which are subjected to chronic insults or injuries. These backs are generally lame. Motions of the spine are little limited, but are painful. There may or may not be muscle spasm.

Referred pain down the sciatic occurs only when the change in relation of the bones to each other is so placed, and to such a degree, that the nerve roots are pinched in their canals. In these chronic cases the tenderness is usually diffuse, rather than localized, over any given joint. The ligaments across the sacrum, sacro iliac joint, and the fascia over the gluteal muscles, are often sore and tender. The straight leg raising test is usually absent.

In these chronic strained cases, it is important to eliminate all foci of infection anywhere in the body, because joints which are relaxed and strained are particularly susceptible to damage by toxic and infectious material.

The treatment of these lower backs, which have been the subject of long continued insult, taxes the ingenuity of the surgeon. It is easy enough to say what the treatment theoretically should be, while it is most difficult to carry it out in practical life.

Theoretically, if the patient is doing work which is too hard for him, he should be given another job. If he is working in a bad cramped position, he should be taught how to work in a different position. If his difficulty is due to bad posture, acquired in childhood perhaps, then he should be taught a new posture. These things are very difficult to do. The practical treatment therefore, of these cases, consists of partial rest provided by means of some form of artificial support, such as belts, braces, corsets and the like. These supports should be so designed as to give the greatest degree of rest to the parts involved. In mild cases they may be comparatively simple. In the more severe cases they have to be more complicated. It is frequently even necessary to apply a plaster jacket for a considerable period of time. When this first period of support has overcome pain, then the process of re-education of the weakened muscles which were originally responsible for the trouble should be begun. This re-education is best obtained by carefully graduated and supervised exercises, which are designed to improve the posture and to improve control of the motions of the spine, and to improve the tone of the muscles themselves. Fundamentally, they are successful, if they succeed in teaching the muscles of the back to be on guard, automatically and constantly, against all the strains which originally produced the bad back in the individual. This habit of alertness on the part of the muscles is surprisingly efficient, when it has been obtained. It becomes automatic rather than voluntary. When it is obtained, then fear of further backache from this cause is eliminated.

Arthritis of the lower spine is of extremely common occurence. It may be of any type, tubercular, gonorrheal, acute infectious, chronic infectious or hypertrophic.

Tuberculosis is too well recognized to require any discussion here except to remark that it must always be carefully considered in chronic low back pain. It is much more frequent in the sacro iliac joints than was formerly supposed.

Acute infectious arthritides are easily recognized as part of a general process and need no further mention.

Chronic arthritis of the lower back whether infectious or hypertrophic is of great importance, and difficult in diagnosis and treatment. The infectious type is usually easy to recognize because other joints in the body are affected. It causes the same type of pain in the lower back as that occurring in the other affected joints. Its treatment is that apportioned to the other joints: the removal of the infectious foci, rest, physiotherapy, diet, and so forth.

Hypertrophic arthritis, the so-called arthritis of old age, frequently occurs in the lower spine, and in no other joints. It is equally true that it may occur in one hip, in the form of malum coxae senilis, in one knee, or in one shoulder. We all recognize it most commonly in the deforming arthritis so frequently seen in elderly people who exhibit Heberdens nodes. This disease is a degenerative process and the best modern opinion believes that it is due to toxins elaborated by bad intestinal chemistry.

The recognition of hypertrophic arthritis in the lower spine may or may not be easy. The typical picture is as follows:

A healthy vigorous man of forty or more years suffers from pain in his lower back which is pretty constant when he is up and about, but which is relieved when he lies down. He complains that his back is stiff and that any considerable motion or effort increases his pain. It hurts him to ride in an automobile. This is, of course, true of all forms of lower backache. Driving an automobile is responsible for many chronic backaches.

Examination of this man shows that the motions of his spine are limited in all directions. Forced motions are painful, and very frequently cause radiating pains down the course of the sciatic or anterior crural nerves. There is little or no muscle spasm, and there are no tender spots to be made out. Absolute diagnosis must depend on the x-ray which shows the characteristic spur formation and lipping around the joints of the spine. On these spurs depends the pain accompanying the condition. Newly formed spurs irritate the capsules of the joint and cause pain. Directly they may impinge upon certain nerve fibres, in which case pain will result in the area supplied by these fibres.

Accompanying the formation of the spurs there is cartilaginous atrophy and atrophy of the ligaments, with progressive stiffening of the individual joints. As new spurs are formed, old ones become rounded off and quiescent, with the result that the pain moves about from place to place, and appears and disappears.

When the lipping and atrophy become sufficient to stop all motion in the affected joint, the pain completely disappears. Trauma in any form is a very important factor in increasing the pain in this condition. This latter fact leads to the keynote in the treatment. It lies in the protection of the back from all insult during acute exacerbations. It may be necessary to put the patient to bed, but ordinarily an efficient support, whether it be a belt, a brace, or a jacket, will be sufficient to allow the patient to carry on a comfortable existence. Heat and the administration of salicylates are very helpful. Most important also is an attempt to eliminate the cause of the disease. In my experience this is best done by careful attention to diet from the point of view of quantity, rather than of kind. Excesses of sugars and starches undoubtedly make these cases worse, but excesses of any sort of food also tend to make them worse. Meat in large quantities is probably harmful, as it is in most other conditions, but a reasonable amount of meat seems to have no bad effect. A simple general diet with special accent laid on foods which tend to keep the bowels open is the most satisfactory one. An amount should be fed which will tend to reduce the patient's weight.

In addition to diet, the most important thing is the clearing of the large intestines. Frequently, these cases will show on examination by an x-ray, a delay of from 72 to 144 hours in the passing of the bismuth meal through the large intestine. If such a delay is present, it is very probable that measures which keep this large intestine clean, such as copious cleansing enemas, acidophilous milk, and intestinal antiseptics, will stop the progress of the disease. If the progress of the disease is stopped, then the pain will disappear.

Malignant disease occurs as a metastatic condition in the vertebra. When it does, it is one of the most dreadful of conditions. The pain is, of course, excruciating and usually controllable only by means of morphia. It is due to pressure of the new growth on the nerve roots. The diagnosis is made by the history of malignant disease elsewhere, and in the later stages by the x-ray picture which is typical.

Anatomic variations in the lower spine are of many sorts. So many in fact that a normal standard is difficult to establish in all details. A wide degree of variation must be admitted within the normal range. The gross variations from this normal range, such as, spina bifida occulta, irregular development of the two sides of a vertebra, fusion of the last lumbar vertebra, with the first sacral, abnormal articulations between the fifth lumbar vertebra and the ilium, all are potential sources of weakness in the mechanism of the lower spine. They do not in themselves ordinarily cause pain, but they do cause weakness in the attachments of the various ligaments, and bad leverage between the joints. When they are found in cases of backache, they must be considered as only potential causes of one of the other forms of backache already described. A good deal of work by individuals has been done on the operative correction of these deformities. For example, the removal of large transverse processes of the fifth lumbar vertebra. Results have not been sufficiently convincing to bring about the widespread use of these operations. On the other hand, the surgical fixation or arthrodesis of diseased or chronically sprained joints in the lower spine has become a fully recognized procedure, in those cases where the conservative methods described above fail to give relief.

Acute muscle strains alone may cause lower back pain, but they are easily controlled and get

well promptly. There are also cases of chronic muscle toxaemia from a diet too high in nitrogenous material. These are amenable to eliminative and dietary measures.

In conclusion, most of the pains in the lower back which are commonly called lumbago, sciatica, sciatic rheumatism, and rheumatism, are due to disturbances in the bones and joints of this region. Occasionally low back pain is due to pelvic disturbances, prostatic enlargement or disease. We must be particularly on our guard also for the rare, but very difficult to recognize, intra-spinal tumor.

HEART DISEASE IN RELATION TO PULMONARY TUBERCULOSIS*

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The heart and lungs are intimately associated anatomically in the thorax, and their functions are closely inter-related and dependent the one upon the other. Disease of either one is apt to affect the structure and function of the other, and the clinical manifestations, therefore, of impaired functions in the two organs may have much in common and appear strikingly similar.

The question of heart disease, its causes and methods of prevention and control is rapidly assuming a place of paramount importance in all public health programs. As the White Plague is being brought more and more under control and the death rate continues steadily to decline, heart disease appears to be on the increase and now ranks as the leading cause of death in the United States registration area. In the age group, ten to fourteen years, heart disease is the main cause of death. From fifteen to nineteen years it is exceeded only by tuberculosis, and from twenty to twenty-four by tuberculosis and pneumonia. After middle age heart disease increases rapidly and again assumes first place among the causes of death and increases in frequency with each succeeding decade. Furthermore, the suffering and invalidism produced by heart disease with the resulting economic loss and social and health problems are comparable in extent only to the tuberculosis situation. Heart associations quite similar to the tuberculosis organizations are increasing in number, and in some localities the two are uniting into one health organization for the purpose of more efficiently dealing with the two problems which have so much in common. It is my purpose, therefore, to point out the parallelism that exists between heart disease and tuberculosis.

It is to be recalled that over ninety per cent of all cases of genuine heart disease fall under three types—rheumatic, syphilitic, and hypertensive. The remaining ten per cent is made up of the less frequent types which include congenital heart disease, acute and subacute bacterial endocarditis, pericarditis, thyroid heart, angina pectoris, and coronary disease. Of the three main types, rheumatic heart disease occurs in childhood and young adult life up to the age of thirty-five, the syphilitic between thirty-five and forty-five, and the hypertensive after the fiftieth year. For the sake of brevity we shall confine our comparison to one type of heart disease. Since it is the rheumatic type that most closely follows tuberculosis, we shall discuss this type. And since for practical purposes all acquired heart disease in young persons under thirty-five years is rheumatic in origin, we must begin with a discussion of rheumatic fever or acute rheumatism. Under the latter term we include acute inflammatory rheumatism, chorea or St. Vitus dance, rheumatic throat infections, indefinite joint pains and growing pains in childhood, erythema nodosum, and other skin manifestations. It is a disease of the entire body—the heart, brain, joints, muscles, skin, throat, pleura and pericaridum.

The etiology of rheumatic fever is still undetermined, although the evidence points strongly in favor of its being a specific strain of streptococcus. It is not contagious like tuberculosis, yet there seems to be a distinct familial tendency and heredity appears to be a factor of some importance. Like tuberculosis the disease is usually contracted in childhood, and the predisposing factors are similar, namely, malnutrition, unsanitary surroundings, exposure, lack of fresh air and sunshine, disease of the upper respiratory tract, focal infections and all other conditions leading to a lowering of body resistance. In both diseases we are apt to find enlarged cervical glands, an accelerated pulse and a slight afternoon rise in temperature, with more or less anemia. The striking similarity of the two infections in children was brought home to me during the past year. For many years I had been calling children with the above findings glandular tuberculosis if, in addition, they gave a positive reaction to tuberculin, and especially if a roentgenogram of the chest showed tracheo-bronchial glandular enlargement. During the past summer while spending some time in cardiac clinics, I observed the same type of malnourished children with anemia, glandular enlargement, accelerated pulse, and afternoon temperature. Here they were diagnosed as rheumatic infections with potential heart disease by the cardiologist. Many of these children would have undoubtedly reacted positively to tuberculin and shown evidence of enlargement of the glands in the hilus of the lung by x-ray. It occurred to me at the time that I had been diagnosing some rheumatic cases glandular tuberculosis, and that the cardiologists were calling some tuberculous cases rheumatic. But since, as we shall see, the treatment is identical in the two conditions, the error is of little consequence.

Following the first attack of rheumatism in

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childhood, the heart becomes affected in from sixty to eighty per cent of the cases. With each subsequent attack the incidence of heart involvment increases and additional cardiac damage results. The tendency to recurrence of rheumatic infections is very great. In fact the infection probably lies dormant in the body in the interval between attacks, ready to flare up into a new attack of arthritis or of chorea, or a new heart infection as a result of a lowering of general body resistance from any cause. The similarity to tuberculosis in this respect is too evident for comment and we should probably speak of arresting a case of rheumatism rather than curing it, just as we do in the case of tuberculosis.

The subsequent history of the rheumatic infection is long and progressive. During the acute attack the mitral valve is usually affected, much less commonly the aortic valve. The myocardium is universally involved as proven by the changes in the electrocardiographic tracings obtained during an attack of acute rheumatic fever. A pericarditis not rarely occurs. The mitral endocarditis results in a roughening of the valve cusps and the formation of vegetations on their free surfaces. This is manifested clinically by a musical systolic murmur at the apex of the heart.

Following this a very slow and progressive inflammatory process ensues, binding the valve leaflets together and resulting in puckering and deformity of the valve orifice. Accompanying this there is a progressive enlargement of the heart. With each recurrence of the acute rheumatic infection, the deforming process is hastened and increased in extent. Then after another period of slow progression of the disease the auricles begin to fibrillate. Finally congestive failure occurs and the patient dies from an insufficiency of the heart muscle, usually before he has reached his fiftieth year. How similar is this all to the smouldering infection of tuberculosis, that begins in childhood and lies more or less dormant only to be activated from time to time by anything which happens to lower the resistance of the individual; and then progresses slowly by a combination of destruction of the lung tissue and healing by fibrosis, which process continues until enough of the pulmonary tissue is destroyed, and enough toxemia results to kill the patient.

Just as in childhood the symptoms of the two infections are quite alike, so in the young adult the two may be very similar, if not really confusing. As we have said, the adult form of rheumatic disease is most apt to manifest itself in the form of a mitral stenosis. Let us picture a case of mitral stenosis with its resulting passive congestion in the lungs, and see how similar are the symptoms to those of the tuberculous patient. The individual is apt to be malnourished and anemic, she may have a cough, dyspnea on exertion, she may become easily fatigued, and run a low grade temperature with an accelerated pulse. She may even have a frank pulmonary hemorrhage. On examination of the lungs there may be changes in the percussion note, and moist rales may be present. It occasionally taxes the diagnostic skill of the expert to differentiate the two conditions.

When we come to consider the course of the two diseases, we again encounter the marked parallelism between them. Just as there are cases of acute fulminating tuberculosis to which the patient succumbs in the course of a few weeks or months, so there are cases of rheumatic carditis in which the entire heart is so severely affected that death quickly ensues. In both diseases there are cases of mild infection which recover spontaneously and leave no permanent damage. Then there are cases of moderate severity which recover in a few months and leave permanently damaged hearts and lungs which do not, however, interfere with their function. There are still others in which, even though the heart or lungs have been extensively damaged and there are well marked physical signs, the patient recovers, the disease becomes arrested with the preservation of a fairly satisfactory function, and the patient may live for years by careful regulation of the general habits of living. In tuberculosis the disease may again become active from time to time while in heart disease recurrent attacks of rheumatic fever are very prone to occur with new damage to the heart after each attack, or the streptoccocus viridans may gain a foothold on the previously damaged valve with a resulting subacute bacterial endocarditis which always ends fatally. And just as in tuberculosis the influence of the infection is general and the function of distant organs impaired, so in cardiac disease the functions of all the organs of the body may be affected by the disturbed circulation.

The prevention of rheumatic heart disease and tuberculosis is quite similar, except that in the latter the specific etiological agent is definitely known and protection against known sources of the germ can be practiced. The child is far more susceptible than the adult to both infections and preventative measures, to be effective, must be brought into play during this dangerous age. All children are probably exposed to both infections at some time or other, and the best method of prevention is to so improve their general health and increase their body resistance that the germ will "fall upon stony places," as Osler so aptly said, and finding the soil unfavorable will fail to take root and grow. This implies supervision of diet, clothing, exercise, sleep, and other health measures, the maintenance of proper weight and growth, the prevention of other infections, particularly those involving the upper respiratory tract; the removal of diseased tonsils and adenoids and other focal infections. Furthermore the improvement of the general health of the child must begin in infancy. The same methods which have been so effective in the prevention of tuberculosis

can be used with equal success in the prevention of the infectious types of heart disease.

There are no drugs which have any influence in arresting the progress of rheumatic heart disease, just as there are none that cure tuberculosis. The treatment, therefore, is again remarkably similar. It consists simply of increasing the resistance of the individual against the infection by rest and all other measures that will improve the general health. Rest is just as important in acute rheumatic cardiac cases as it is in pulmonary tuberculosis and should be continued until the temperature has returned to normal and remained so for some time. Fever is practically always present in cardiac failure in childhood. The failure is due to an active infection in the heart which diminishes the functional capacity of an actively inflamed heart muscle, and it may last from a few weeks to many months. Hospitals are compelled to reserve their beds for acutely ill patients, and the convalescent cardiac patient, running a low grade temperature, is sent home as soon as the acute stage has passed, where he is without supervision of his rest, exercise and general routine. For the treatment of the tuberculosis patient there is the sanitorium where diet, rest, and exercise are carefully supervised, and the individual is taught to live within the bounds of his disability. There is great need for similar institutions for the treatment of cardiac patients. Cardiac convalescent homes are being established in some localities where the child or adult is continued under proper supervision from the time he leaves the hospital until he can be safely returned home. Here, also, children with recurring attacks of rheumatic fever and chorea with their resulting heart reinfections—not sick enough for the hospital, but requiring supervision of rest and exercise—can be sent for treatment. It seems to be the mutual purpose of the tuberculosis and heart associations that in the future when the tuberculosis problem has been more nearly solved, many sanitorium beds at present being used in the treatment of tuberculosis will become available for the treatment of cardiac cases.

Once the infection has subsided in either cardiac disease or tuberculosis, the chief aim of the physician is to maintain the patient's general health by all rules of hygiene, to have him live within his limits, and to protect him against further damage to his disabled organ.

Before closing, I wish to mention an entirely different angle of the question of heart disease and tuberculosis. Disease of either the heart or lungs is most certain to produce pathological changes and clinical symptoms in the other. That pulmonary tuberculosis may also affect the heart is not always appreciated, and strangely the latter has not received the consideration it deserves. This has been due to our narrow view of looking upon tuberculosis as a local disease of the lungs instead of viewing it as an infection of the pulmonary tissue from which every organ and cell of the body is injured. And the heart comes in for an unusual amount of disturbances both in its texture and function. The changes in the myocardium in a slow-going toxemia like tuberculosis are not as evident as in one of high grade like diphtheria, yet they are no less a factor in determining the outcome. As Pottenger says, "A good heart is the best asset that a patient suffering from tuberculosis can have. It serves him well during the time when he is struggling with the disease as an infection capable of arrestment and it usually proves to be the determining factor as the disease progresses."

In tuberculosis the valves are usually spared while the myocardium suffers the brunt of the attack. The heart symptoms are often overshadowed by phenomena occurring in the lungs and those resulting from toxemia. These facts may partly account for the little attention paid to the heart. Clinically there is nothing specific about the tuberculous heart, no symptom or combination of symptoms that is not seen in functional and organic disease of the heart from other causes. The important thing is to recognize these cases early and treat them properly. The majority of deaths in tuberculosis are due to an exhausted myocardium and all things else being equal, the patient with the good and well cared for heart has a decided advantage in his struggle for overcoming the disease. If the early symptoms of heart failure are recognized and the patient treated as a cardiac case as well as one of tuberculosis, the crisis can often be averted and a fatal outcome prevented.

SUMMARY

1. Heart disease is becoming a public health problem of the first magnitude, and it will probably eventually overshadow the tuberculosis problem.

2. The onset, symptoms, course and treatment of the two diseases are strikingly similar.

3. There is a need for convalescent beds for the treatment of cardiac cases, similar to those in use for the treatment of tuberculosis patients; and tuberculosis sanatoria may eventually be utilized for this purpose.

4. The prevention of the infectious types of heart disease is promoted by the same broad disease-prevention campaigns used in the anti-tuberculosis movement.

5. The heart deserves more consideration than it usually receives in the treatment of pulmonary tuberculosis.

THE OBSTRUCTED APPENDIX

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In spite of the amount of literature available, a brief review of the history, clinical findings and underlying pathology in a few cases of appendicitis would seem to be worth while.

As pointed out by Dr. Wilkie in a recent article, an inflammation may originate in the wall of the appendix or there may develop an obstruction of its lumen. The two types of pathology often result in a very different symptomatology, course and prognosis.

Figure 1 depicts a specimen removed from a patient with a classical text-book case of acute appendicitis. At the onset there was generalized abdominal pain which localized as a tenderness



Figure 1.

within eighteen hours over McBurney's point. Vomiting, constipation, slight rise of temperature and mild leucocytosis were all present. At operation the omentum was found to have completely surrounded the appendix, thus protecting the abdominal cavity from invasion should perforation take place. This is the type of case well understood, rarely undiagnosed, and in spite of delay the worst that usually happens is the formation of a localized abscess which can easily be drained.

An altogether different situation is represented by the specimen pictured in Figure 2. The patient, a young man, aged twenty-six, was taken with violent epigastric pain. The attack was associated with vomiting and a temperature of 102 degrees F. Two injections of morphine were given by the attending physician before relief could be obtained. The severe pain recurred at intervals and a clinical diagnosis of gall-bladder colic was made. Eight hours later there was practically no pain and the patient carried a temperature of 99.2 degrees F., a pulse of 80, and a leucocyte count of 9000. There was no jaundice. Palpation revealed only a slight tenderness in the right quadrant. In a few hours the pulse had risen to 96 and the temperature was 99.0 degrees F. The abdominal findings were unchanged. At operation the appendix was found to be completely gangrenous but unperforated. It was hung like a banana on a stem with no sign of adhesions or peritoneal reaction. Its con-



Figure 2.

tent consisted of decaying fecal matter and its lumen at the base was completely closed.

Figure 3, pictures a specimen removed from a young married woman who upon arising was seized with nausea and a cramp-like pain in the epigastrium. She ate a small amount of breakfast which was followed by a normal bowel movement. In a half hour she was seized with another



Figure 3.

cramp and this time she vomited. This continued at about hourly intervals until afternoon. Her temperature and pulse at that time were normal and the leucocyte count 8000. Tenderness on deep pressure in the right lower quadrant was only slightly increased. Operation revealed appendix, swollen and edematous containing a small

amount of muco-pus and a fecalith firmly impacted at the base completely obstructing its lumen. As in the preceding case there was no peritoneal reaction preparatory to an impending perforation.

DISCUSSION

The pathology in the first case originated in the appendix wall itself, probably either through a break in the mucosa with direct extension or through the blood stream. As the inflammation increased a peri-appendicitis developed with a zone of reaction in the surrounding peritoneum. The friendly omentum being thus stimulated walled off the offending organ from the rest of the abdominal cavity. Perforation here was comparatively free from danger as notice had been given and preparation had been made.

In the next two cases, the pathology is dependent upon the content of the appendix. The lumen was obstructed in both, one by scar tissue and the other by a fecalith. Gangrene occurred quickly in one because the organ was filled with fecal matter containing anarobic bacteria suddenly placed under ideal incubation conditions. Edema and swelling alone occurred in the other as there was practically no fecal content. In neither was there any local reaction about the diseased organ. The contents of a large appendix as pictured in Figure 2, poured into an unprepared abdomen will almost surely lead to a generalized peritonitis and death. The specimen in Figure 3 would probably have gone on to the formation of a mucocele or an empyema as described by Wilkie in his experimental work on rabbits.

The history and clinical findings in the first case usually run true to form as described in the text-books, but in the other two there may be such little resemblance to the classical picture that the appendix is disregarded altogether. There may be no rise in temperature, no leucocytosis, no local tenderness and no nausea or vomiting in the presence of a gangrenous appendix. Even in the absence of the above there is always a history of recurring colicy pains previous to the onset of gangrene, after which the onset of peritonitis is soon recognized. Such a history was mistaken for labor pains in a patient almost at term. Fortunately the patient had a Caesarean section planned and the real condition was thus accidentally discovered.

It is not uncommon to have an obstructive type grafted upon the classical type. The attack may seem to be subsiding when a sudden paroxysm of pain may set in and the patient have to be rushed to operation. In such cases the preceding inflammation may have so narrowed the lumen that obstruction takes place and perforation may occur before the patient can be transported and the surgeon called. This is often the outcome after recurring mild attacks while the patient waits for the remission that heretofore has always occurred.

So-called chronic appendicitis is often found to be an appendix containing one or more fecaliths which are forced along the lumen with each peristaltic wave blocking the outlet completely for short intervals of time at the narrowed base, like a ball valve. Should the appendix be able to empty itself the distress is relieved at once. This picture of partial obstruction is often the source of a chronic bowel irritation which will respond to neither diet nor medication.

The man in general practice should be able to differentiate between an acute appendicitis and an acute appendicular obstruction and act accordingly. In the former it may be safe to wait for localization. The latter should be handled with the dispatch of a strangulated intestine and the patient rushed to operation without a moment's delay. Gangrene and perforation may occur within six hours from the onset of symptoms. In children this is frequently the case due probably to congenital anatomical conditions such as aberrant bands or kinks narrowing the lumen and making obstruction easy.

SUMMARY

1. Many physicians lack confidence in diagnosis of acute appendicitis because they do not understand the underlying pathology.

2. Disease of the appendix may be an inflammation of its wall or an acute obstruction of its lumen as described by D. P. D. Wilkie of Edinburg, Scotland.

3. The prognosis in acute appendicular obstruction depends upon the fecal content of the organ. Early gangrene and perforation occur when fecal matter is bottled up in the appendix.

4. The most constant clinical symptom of appendicular obstruction is recurring spasms of colicy pain. Other classical symptoms of acute appendicitis may or may not be present.

5. Acute appendicular obstruction when recognized should be rushed to operation just as promptly as a case of strangulated hernia.

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REPORT OF CASE OF CANCER OF THE LUNG

G. C. JOHNSON, M.D. AND W. R. HURST, M.D.

EVANSVILLE, INDIANA

The reasons for reporting this case are the rarity of the condition and the difficulty of diagnosis.

Geo. S. C. Age sixty-nine years; married. Business man and philanthropist.

Family history: Father and mother died young; cause not known. One brother died of heart disease. One son developed tuberculosis while in college and had to give up school for one year, from which time he has been well.

Previous diseases: Childhood diseases; also fever and ague in early life, otherwise, well un-

til seven years ago when he developed some heart trouble, high blood pressure and considerable indigestion for which he was treated by Dr. W. R. Hurst, his family physician.

December, 1924, he had an attack of flu from which he did not fully recover. May 21, 1925, he came to the writer for a chest examination. At this time he complained of shortness of breath, some cough and expectoration. General appearance good. Normal weight, 135 pounds; present weight, 134 pounds. Blood pressure, 135-90. Pulse, 100; temperature, 98-2; respiration, 20. Nose and throat normal.

Chest: Diminished mobility on left. Flatness with absence of breath sounds all over left lung. Heart dullness displaced far over to right.

X-ray of chest showed left chest impenetrable to light except over a small area above second rib.

On exploration with needle, a clear, straw colored fluid was removed. By repeated aspirations, this fluid was gradually removed, until June 13, 1925, when we were able to get an x-ray picture of the lung which showed nothing abnormal. Fluid returned very rapidly and it was necessary to aspirate every two or three weeks to give relief from the shortness of breath.

July 27, 1925, a specimen of the fluid was sent to Walker Hospital Laboratory for examination and guinea pig inoculation. Cell count was normal. Nine weeks later this pig showed no evidence of tuberculosis except in one testicle; this was considered inconclusive and probably an accident. Blood examination and differential count were normal. General condition remained good but fluid continued to form, the left pleural cavity filling in less than a month.

During November, 1925, he consulted Dr. Herrick of Chicago, and spent four days in the Presbyterian Hospital, under observation. Malignancy was suspected but no proof found. Dr. Herrick's report was, "Probably Tuberculosis," which had been our diagnosis up to that time. Dr. Herrick made a guinea pig inoculation with the fluid which was negative for tuberculosis.

Treatment up to this time had been much rest in bed and first class general care, with removal of fluid when it became uncomfortable.

After his return from Chicago, Alpine sun lamp treatments were given and a tuberculin test was made obtaining only a mild local and no general reaction. His temperature was usually sub-normal, rarely coming up to normal. Many x-ray pictures were taken by both myself and Dr. W. R. Cleveland, x-ray specialist; and gradually we noted that they all contained a peculiar circular band about three inches in diameter, in the upper lobe of the left lung, which we interpreted as being a cyst wall which might be secreting the fluid which had broken through into the pleural cavity. March 26, 1926, he was seen by Dr. J. S. Pritchard of Battle Creek, Michigan, who was in our city, and he made an injection of lipiodol into the bronchi of left chest, following which, many x-ray pictures were taken at different angles. He was inclined to agree with the "cyst" diagnosis. No lipiodol could be forced into this cyst area. Following this injection the fluid stopped forming, only three aspirations being necessary after this treatment. The last aspiration was June 24, 1926. His general condition remained about the same except that pain developed over lower part of left chest.

During this time he had considerable prostatic trouble, with a trace of albumen and some pus in the urine, for which he was treated by a genito-urinary specialist and gradually improved.

Blood count August 23, 1926, showed: Red cells, 4,000,000; white cells, 8,600; polys, 70; S. L., 27; L. M., 3.

September 26, 1926, patient consulted Dr. Cowie of Ann Arbor, Michigan, because of digestive troubles; spending two or three weeks there under observation and treatment. Dr. Cowie's diagnosis was, "Pleurisy with effusion, due to flu." Malignancy was suspected, but no proof found. Many x-ray pictures were taken by Dr. Hickey, at University Hospital. October 1, 1926, Alpine sun lamp treatments were continued. No fluid in chest. Much pain over lower left chest. Losing weight gradually. October 21, 1926, weight 117 pounds. Very sensitive to cold which makes the pain worse. Blood count: Hem., 80 per cent; red cells, 4,000,000; polys., 88; S. L., 10; L. M., 2.

Held weight during winter, and weighed 117½ pounds, April 27, 1927. X-ray at this time showed right lung clear throughout. Increased haziness over left lung so that very little lung structure can be seen; this interpreted as due to increasing thickness of pleura.

In June, 1927, he returned to Dr. Cowie, at Ann Arbor, for further observation which showed nothing definite.

July 1, 1927, home. Thin. Much pain, left lower chest.

October 27, 1927, his weight was 105 pounds. Chest examination showed some medium coarse rales from the level of right nipple to base. No rales had ever been heard in this region before. No other changes noted.

Fluoroscope and stereo-x-ray showed some infiltration at the base of right lung, which previously had always been clear. Near the center of the diaphragm there was a distinct pyramidal shadow extending up into the lung. This was best noted under the fluoroscope upon taking a deep breath. He complained of increasing dyspnea and weakness. Blood count: Hemo., 80 per cent; red cells, 4,000,000; white cells, 11,000; polys., 80; S. L., 18; Eosin, 2. Diagnosis at this time was "Malignancy of the Lung."

November 22, 1927, he left for Phoenix, Arizona, where he was under the care of Frank J. Milloy, M.D., of the Southwest Clinic, until his

death, December 10, 1927. An autopsy was held and Dr. Milloy reports as follows:

"We found a cylindrical cell carcinoma involving the pleura of both sides and both lungs. There was no evidence of any primary focus below the diaphragm, so it was the opinion of the pathologists that the primary focus was the bronchial epithelium."

Our only regret was that we were not able to see the autopsy and search the left lung for evidence of a cyst.

The misleading signs in this case were:

(1) The clear pleural fluid with a normal cell count.

(2) Normal blood picture almost to the last.

(3) No x-ray changes that could not be explained by thickened pleura which follows nearly all pleurisy with effusion.

The suspicious signs were:

(1) The effusion that persisted for one and a half years, followed by persistent pain in left lower chest.

(2) Slow loss of weight and strength.

LITTLE GLIMPSES OF MEDICAL AFRICA

TERRE HAUTE

In my recent sojourn to this interesting but little understood continent, I was impressed with the medical work here found. It is gratifying to know that throughout this big world, where superstitution does not hold forth, medicine and surgery are rapidly being reduced to a science.

Enroute I first stopped at Madeira where I visited the infirmary located at Funchal. Here I was disappointed, but nevertheless interested. This hospital is under Portuguese rule which means a slipping in sanitation. The Jesuits were Portuguese; they did much for the human race. It was they who discovered the properties of quinine from the Peruvian bark. They also put "Yerba-Mata", known as Paraguay tea, on the map. The infirmary consists of a long room and an altar for administration of the sacrament to the sick. One side is divided into wards, each of which is just long enough to contain a bed. Back of these wards runs a long gallery with which each ward communicates by a door, making it convenient to attend to the sick without disturbing others. This provision is splendidly adapted to the prevailing custom in which friends and relatives are permitted or, rather, prevailed upon, to attend the sick. As the medicine is left at the bedside, little skill is required for its administration.

From here I stopped at the Canary Islands, where San Martin hospital located at Las Palmas was visited. Here I found a pleasing contrast between this hospital and the one in Funchal. San Martin has an up-to-date operating room, carefully kept. The x-ray room is equipped with English and French machines which are more crude and heavier than those used in the United States; nevertheless I saw some excellent plates. The private rooms and wards are clean, but simple in arrangements. They do not have the system or order that is so pronounced in the States. This hospital is under Catholic management, having thirty doctors on the staff, all capable in their line of work. This beautiful island is free of malarial and yellow fever, and is practically free of typhoid, having splendid water. Among the poorer natives, dysenteric conditions are common, as little attention is given to the preparation of vegetables and food. After a few days' pleasant sailing, we disembarked at Dakar, the principal port of Senegal, West Africa. The Colonial hospital, located in this extremely hot place, was the only one in entire Africa in which I did not feel welcome. This might have been attributed to the fact that just a few days previously, yellow fever quarantine had been lifted in which epidemic some three hundred were stricken with the deadly disease. Doctor Stokes, connected with the Research Institute, was among the unfortunates. However, with some reluctancy I was admitted. Dakar consists chiefly of blacks, and very few Europeans. It is a splendid place for the study of tropical diseases. The hospital is attractively located at the edge of the town, receiving the full benefit of the tropical sun.

Because of the topography, Dakar has the reputation of having the most penetrating sun rays in the world. As a consequence care must be taken in the wearing of the helmet or topee. Sun stroke is frequent even among the natives. This hospital is arranged in wards, two stories in height, the rooms being well lighted and aired. Each room is supposed to be screened but it did not require close scruntiny to find many defective screens through which flies and mosquitoes had free access. The appointment of the operating room was simple, so arranged that sunlight and air were very accessible. As a precaution against yellow and malarial fever the natives are obliged to retire in their screened huts after sundown. The few Europeans must be protected after sun down with ample mosquito netting around their heads; they must wear gloves; the legs and feet must also be properly protected. This precaution is strictly followed.

Free town—Sierre Leona, is an English town, a country from which many of our old American slaves originated. Much superstitution exists here and as a consequence the witch doctor has much influence among the natives.

Every one keeps in his home or about his person something that he highly reveres, and that he imagines will protect him from misfortune. This may be a stick, bone, or a monkey's skull. The native dances were interesting from this point of view. Free town, small as it is, is said to be the most cosmopolitan town in the world. The Cre-

oles predominate. It also has the finest natural harbor in West Africa. The secret societies of the natives are extremely interesting. The "Bunder" is a society which every girl is compelled to join. She is initiated into the functions of wife, mother and homekeeper. I was told by the chief of police that a minor operation was performed upon the clitoris of the girls by the old witch. This prevented unfaithfulness. I was unable to determine the character of the operation. The after ceremony is very interesting in which the girls dance in the most grotesque and fanciful manner. These girls are then eligible to marriage and the man who has the most to offer the girl's father is the favored one. Perhaps the most strange societies are the Human Leopard and Alligator societies. These are murder societies and are responsible for many crimes of a mysterious nature. The "bor firma", a medicine used by this cult, is made from portions of the human body. This is used in conjunction with an ointment made of human fat taken from murdered victims. This portion of West Africa has the reputation of being very unhealthful for the whites and probably stands at the head of the list with the title of "the white man's grave."

Advancement made in medical science and the slow education of the natives have added materially to the longevity of life. The climate is not conducive to the well being of children, especially when so little regard is given to dietetics. Dysentery, digestive disturbances and the aestivo-autumnal type of malarial are the prevailing diseases.

The Colonial hospital is well constructed with its many wards to care for the needs of the people, but the natives are very prejudiced against medical care, preferring their own primitive "medical man." All over the country are small missions which are slowly educating these people to better living. Precaution is given against going barefooted or getting the feet or ankles wet with stagnant water, particularly in the vicinity of native villages.

It is claimed the mud existing around these places is a source of infection for ankylostomiasis (hook worm) and bilharzia. Emphasis is placed on the small consumption of alcohol and meat. The eating of much fruit is urged as also the importance of washing the vegetables.

The treatment of malarial fever is classic and nothing new was learned. The black water fever is common but infrequent among Europeans. The sleeping sickness is rather prevalent in West Africa but not so much as in the Uganda district. Doctor Rolland of the Research Laboratory showed me some of the tsetse flies which cause the sleeping sickness. The tsetse fly (Glossina-Palpalis) is about the size of the blue bottle fly, bluish or greenish in color, when at rest, its wings are closed one over the other and lie flat along the back. In Victoria Falls I learned the fly was somewhat different in this section. Dr. Rolland also showed me interesting malarial and yellow fever mosquitoes. At that same institute good work is being done in malarialogy. It was tentatively proven that the malarial plasmodium does not find its way to the child through the placental circulation, but was arrested at this point.

Dr. Steward of the hospital informed me there was much enteric trouble; that they had few cases of gall bladder and appendicitis diseases and fewer cases requiring operation. Fibroid cases were frequent as the negro race seemed predisposed toward it.

I was interested in knowing the Kolo nut was indigenous to this country and much used for its stimulating properties. I learned that the natives and the native monkeys of this section are immune to yellow fever. Monkeys must be imported from other countries when used for experiment.

Enroute to Southern Africa I visited St. Helena, the exiled home of Napoleon. Here is a solitary island in the south Atlantic off the coast of Africa. It has an interesting little hospital called the Colony hospital located on a little hill at the side of the city, among a cluster of Eucaliptus trees. The lady superintendent, of marked energy, was much pleased to be of use to an American. I was shown the operating room, which was constructed on the most primitive lines, floored with wide cypress boards, but spotless from frequent scrubbing. The attendant told me they depended mostly on clear water, soap, air and sunlight for their freedom from infection. Inquiry as to the frequency of infected gall bladder, appendicitis, etc., seemed to elicit surprise. The islanders seem free from contagious and infectious diseases, due no doubt to the fact they all seem to live out of doors. When closely questioned as to the frequent diseases found here, the answer was venereal diseases. The natives seem to exercise little choice as to their marital relations.

Incidentally I was shown the destructive properties of the little white ant. This little termite bores into any wood excepting teak, mahogany or ebony, thus destroying its structure and leaving only a thin shell. The pillars supporting the staircase leading up to the wards were unsafe because of these attacks. The superintendent seemed more concerned in these parasites than in those infecting the human temple.

The next hospitals visited were those in Cape Town Colony, South Africa. These are all under English rule which means a high standard. The one visited at Cape Town was Somerset, being a municipal hospital of two hundred beds. The rooms are long and airy, and especially is this true of the operating rooms. All through Union South Africa, English and American instruments are used. Preference is made, how-

ever, to the German x-ray therapy machine. The American made x-ray machine was frequently seen, mostly, however, for diagnostic work. In all the Union South African hospitals much surgery is being done. The type of diseases found here are similar to those found in our States, as Union South Africa is about the same climate as our southern states south of Indiana, being as far south of the equator as we are north. The hospitals along the line as far north as Victory Falls, are very similar. At Victoria Falls is an interesting retreat for lepers. The climate in Orange Free State — Transvaal — Rhodesia— Bechuanaland, is very invigorating, especially at night. The air is free of organic matter and highly charged with ozone. As a consequence, many small health resorts are frequently seen for the cure and prevention of tuberculosis. No place in the world have I enjoyed such delicious fruit as found in Cape Town Colony. This fact coupled with the climatic conditions make it a natural health resort. In some of the diamond and gold districts are found small hospitals that are examplary in their management. In the diamond quarters of Kimberly the x-ray is used in recovering diamonds that are secreted on or about the natives. The hospital visited in Pretoria, Transvaal, was the old hospital, the foundation stone of which was laid by Paul Kruger. It was built by the Republic. It has about two hundred and twenty-five beds, the wards are in the form of wings and located among flowers indigenous to this climate. There is a nursing school connected with the hospital with an attendance of some eighty students. This, as other hospitals in the Union, is well equipped. The x-ray is of American make. Much stress is given to the children's ward. The attention to dietetics and hygiene has reduced the mortality rate considerably. I saw many cases of tuberculosis of the bone, especially of the hip. The treatment consists of rest, sunlight and diet.

In the museum I was interested in the peculiar formation found on the bodies of some of the Bushwomen. Some authorities claim these masses of fat were for consumption in time of famine or need, similar to the camel hump. My observation would force me to the conclusion that they were pathological masses of fat due to a lipomata. I was unable to obtain correct information from any medical man. Pretoria also has a splendid bacteriological laboratory, and a small hospital for lepers with but a few cases. The entire Union of South Africa impressed me as being quite free of cripples and repulsive diseases, due probably to its national youth. Johannesburg is the hub of Union South Africa and therefore contains the largest hospital in the Union. It has some one thousand beds and is located on the slope of the city, presenting a very attractive view. The gardens leading up to the entrance are very artistically arranged.

There is a medical school near by; being a strong competitor to the one in Cape Town, the requirements for medical education are standard. Many of the students, however, finish their medical education in England. The hospital is well equipped, having one of the best German and American x-ray outfits for deep therapy and diagnostic work I have ever seen. The operating rooms are constructed on modern lines, being faced with American glazed tile. Specialty units are complete, and are equipped with the latest devices. The garden affords opportunity for the out of doors. Throughout the Union much stress is placed on the out of doors. As a rule, in this hospital, more conservatism is given to surgery, and especially is this true in the treatment of duodenal ulcer. Appendectomy is performed immediately after the diagnosis is made. Few cases are seen among the natives. South African Institute for malarial research occupies a site of over six acres adjacent to the hospital. This institute has some of England's prominent men. It is founded and established for the purpose of conducting researches and investigations with a view to the prevention and treatment of human disease. The building is admirably placed; being of English Renaissance. The laboratories have a southern exposure for light. One wing accommodates the Miners Phthisis Medical Bureau, in which department splendid research is being done. The workers in the various mines of Union South Africa show a high mortality rate from fibrosis or phthisis of the lung. The institute also includes museum, lecture, theatre, post mortem and isolation laboratories. The Routine Division is concerned with the application of accepted principles in the diagnosis and treatment of disease. The Research Division administers a preventitive inoculation against lobar pneumonia so prevalent among the natives working in the gold and diamond mines. Work also is being done in connection with silicosis, bilharziasis, cerebro-spinal meningitis, plague and epidemic influenza. The investigations of these subjects are contributed to technical journals. It might be interesting to know that the government and municipalities have provided hospitals in the leading towns of Union South Africa. As I see it, the greatest medical curse in Africa is venereal disease, among both the blacks and the whites. The subject is now receiving official consideration. The consensus of opinion is that it was introduced by the white race. In East Africa, Uganda, etc., it probably was introduced by the Arabs and Spanish. Many of the Baganda women are unfertile, many of the children are stillborn, and two-thirds of the remainder die at an early age. The mortality from snake bites has greatly been reduced since the subject has had scientific study. The snake farm at Port Elizabeth is conducted similarly to the one in Sao Paulo in South America. Serum is used for the bite of a snake; this, used

in conjunction with other accepted methods, has given gratifying results.

The next hospital visited was a Portuguese hospital in Mozambique, a hospital of two hundred beds. I was much interested in the careless disregard for sanitation. The wards were untidy and swarming with flies. The bed coverings were filthy and the floors and walls were besmeared with dirt. In the center of the wards were pan-like receptacles for the convenience of the patients in expectorating. The patients were unkempt and looked as if they were in need of baths. In the European wards the conditions were somewhat improved but far from satisfactory from our point of view. I was shown several cases of interest; especially cases of "yaw", a skin disease very similiar in appearance to syphilis. I was informed they clear up very quickly with neo salvarsan injection. The vast majority of cases in the hospital were syphilis or the result of this disease. The doctor told me this disease was the scourge of the country, being originally brought over in the days of De Gama and the early navigators. The laboratory was poorly equipped and as carelessly maintained. I was interested in the water supply. In Mozambique, wells are impracticable because the water is brackish. Rain water is the only source and that is available about five times yearly. The hospital is provided with immense reservoirs. Into one of these the doctor took me. Opening an immense trap door, I was ushered into a subterranean chamber, which reminded me of some of those secret passageways found among the ruins of Mexico. The chamber was probably thirty feet deep, forty feet wide and one hundred feet long. At the bottom extended stone steps disappearing in the water. This water is boiled before using. Notwithstanding the precaution taken, the inhabitants of this country have much intestinal trouble. In the hospital of two hundred beds they average four appendectomies per year with a mortality rate of one in four.

The natives in Nossibe, Madagascar, are of a good physical type, having an attractive skin, strong white teeth and healthy gums. The diet is simple, consisting chiefly of fruit, meal and vegetables. This country is under French control, consequently the hospital visited was French, but not up to the French standard. The cases shown were not of special interest inasmuch as the treatment was similar to that used by us. The chief thing of interest was the operating room, and especially the operating table which looked as if it had been taken out of Noah's ark. It was a very crude affair, looking more like a primitive bench. The top consisted of a thick, rough board, about six feet in length, in the center of which was a hole through which the blood drained into an old dirty earthen jar. At the foot end were two leg rests adjusted with hinges. These rests were huge pieces of lumber hollowed out, on which the legs rested. The table and operating room was in a very unsanitary condition. The instruments were crude, kept in a case devoid of glass, having the appearance of never having been washed. Their major work consisted of hernias. Abdominal operations are a rarity. I was unable to determine the percentage of infection. The rooms throughout the hospital were untidy. The linens and bedspreads were "untouchable," nevertheless they harmonized with the appointment of the hospital.

A visit to Nairobi from Mombasa convinced me that the prevailing illness in British East Africa was infectious diseases. The malarial mosquito, tsetse fly, jigger and tick seem to elicit much concern. Enteric diseases are common but few cases of liver, stomach, and appendiceal diseases, excepting those found among the Europeans. The native hospital at Mombasa was very neat and clean. The superintendent is a European with Hindu physicians of high training as assistants. The minor dressings, etc., are done by native orderlies, who are careful and painstaking. The operating room and wards are neat and clean, the operating room being well equipped with all necessary paraphernalia. The records seemed more carefully kept than those found in hospitals of the same size. This hospital has about one hundred and twenty-five beds for natives. Few abdominal operations are performed and appendectomy is a rarity among the natives. Several cases of enteric and malarial fever, osteomyelitis, fractures, etc., were seen. The treatment is similar to ours. For some reason they have many cases of hook worm disease, the treatment being oil of Chenopodium. In Zanzibar near the old slave market, where natives were sold as cattle not many years ago, is an interesting but small hospital. The appointment is similar to those previously visited. The patients were natives, suffering from hook worm, malarial and spirilla fever. The wards are clean and the Swahilie are taught to assist in minor work. The native hospital near Victory Gardens and alongside the jail was of more medical interest. The doctor in charge was very interested in his work. He corrobrated the statement heard so frequently that appendicitis, stomach and duodenal ulcer were a rarity among the natives. He saw few cases of liver infection and those few were probably due to spirilla infection. Many cases of malaria, hook worm, elephantiasis, etc., are seen. Syphilis and diseases arising therefrom are very common. This hospital has about one hundred beds. I was impressed with its sanitation, and the careful records kept of the work. The operating room was large and airy but would not check up one hundred per cent, using our standard as comparison. Studying their annual reports and records I could not fail to observe that their success of treatment, in general diseases, was equal to ours. The diseases most prevalent among the natives are infectious diseases, disease of the digestive sys-

tem, disease of the skin, and respiratory disease. Malaria rank first, hook worm is very common, being treated with carbontetrachloride and oil of Chenopodium. Several years ago they had an epidemic of dengue. The military hospital in the Sudan is the ordinary military hospital found elsewhere among the English. If any thing, the appointments were a little below normal standard. This hospital has about forty beds but is being enlarged. Most of the diseases are those carried in from the interior. The x-ray machine is rather crude and the work correspondingly unsatisfactory. The hospital is pleasantly located on the banks of the Blue Nile. The "Lady Baker," a hospital river boat, is interesting, inasmuch as this boat patrols the upper Nile in charge of medical officers and native servants. She is fitted with wards and an operating room. This little Nile boat educates the natives to sanitary precautions. The Lord Kitchener School of Medicine trains the educated natives to become assistant doctors. This year they graduated six students. The hospitals in Cairo are so modern that they are of little interest to this article. With few exceptions the hospitals visited are doing good work in preventative medicine. Epidemic disease, plague, amaebic dysentery, tuberculosis, leprosy, etc., are greatly reduced. Small hospitals and medical missions are distributed throughout the continent. The process of educating the natives is slow, as much superstition and prejudice must be overcome. With the assistance of medical science much of this uninhabitable country will be as habitable as our Panama Canal zone.

SPECIAL ARTICLES

THE PHYSICIAN'S WILL*

F. A. SCHACK, TRUST OFFICER
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Shakespeare says:

"Let's choose Executors and talk of Wills;
And yet not so—for what can we bequeathe save our deposed bodies to the ground."

The importance of a will is usually not appreciated. A will constitutes the final expression of your wishes respecting the labor of a lifetime. A will is that which is to live after you. Future happiness and welfare of the persons and objects dear to you depend upon the careful and faithful construction of your will.

Your Will: You are the person who is most familiar with your own property. You understand the temperament and abilities of your various heirs. This makes you the best judge as to how your property should be distributed. You may desire to remember some person dependent on you who has no legal claim, or some friend who has done you a great service, or a certain charity whose welfare might be threatened if your support is withdrawn. There are many, many reasons why your will should be drawn and drawn today. Would it not be advisable to attend to this duty now?

Of course, "no one is so old as to think that he may not live a year." If it be winter, the average man of any age is sure that he will carry on to see the robins return and to breathe fresh life with the spring. And, in summer, he knows full well that he is not destined to pass out until he has harvested this year's garden crop. Death is never imminent; we take a day off to attend the funeral of a man whose desk was next to ours in the office, and returning from the cemetery, we say to ourselves, "I ought to put my affairs in shape, so that my wife will be alright in case anything should happen to me." But we do not do it. "I'm right in the midst of things, now," we say. "In another ten years, I'll have something worth while writing down in a will. Then, I'll want to think the matter over carefully and arrange a fair division between my wife and the children. But, it's hardly worth while troubling about now." The man in the scripture is typical of most of us. "Things are going well with me," he said in effect. "I will pull down my barns and build greater." That night his soul was required of him.

Is a Will a Luxury? Another reason why will making is not popular is because there is a general impression that a will is a luxury for the rich. Mr. Millionaire, when he dies, will leave his estate carefully guarded by a long legal document; but the man who has nothing but a house and a lot and five hundred dollars in the bank assumes that it isn't enough to bother the court about. So, he dies, and his wife, who might, under a proper will have entered into the enjoyment of his estate at once with very little formality, finds herself compelled to give bond and go through an immense amount of red tape, and is fortunate if she is not involved with irate relatives before negotiations are completed. Even if she comes through safely, she has paid more than she can afford in fees and charges, all of which would have been largely obviated by a proper will. A rich man's will may be a luxury, but it is a necessity of the man of small means; and the smaller the estate, the more a will is essential.

Any will at all is better than no will. But the will which simply leaves money or other property in bulk to a woman who has never had even her own checking account; or to children utterly unskilled in business affairs, or even to the guardianship of his next best friend, who is busy with his own interests, is a doubtful blessing in most cases. Your will must be properly drawn. No layman should be entrusted with the making of your will. It should, in all cases, be prepared by a skilled

*This is the second paper on this subject, the first having been published in the June number of THE JOURNAL.

lawyer. Every conceivable contingency must be taken into consideration. It should be drawn by one possessing legal skill and foresight, capable of providing for all possible events, as your will speaks from the death and not from the date of its making. It must be fully, yet concisely, worded. But who is to be called upon to execute your directions? It must be someone who will live longer than the testator, or the person making the will. It must be someone who, by experience and ability, is qualified to understand the duties entrusted to him in the most economical way and with the greatest safety; it must be someone who can be held responsible for any errors he may make, having sufficient resources of his own to permit reimbursement to the estate for losses incurred through his fault; it must be someone who will not show favoritism to one of the heirs to the disadvantage of the others; and it must be someone who is willing to undertake the duties and responsibilities, and who is able to devote all of his time and energy to the task. What individual combines all of these qualifications?

If your will is already made, it is your privilege to change it. You should name a bank with trust powers as executor or trustee. Have your lawyer add a postscript, called a codicil, effecting the change.

Confidential Service: The personal advice of the trust department of a bank is at the disposal of yourself and your legal advisor in those cases wherein the institution is to be named as executor-trustee, or guardian. It should be understood by those contemplating the service of any Trust Department that they may freely and frankly discuss their private and family affairs without any fear of violation of the strictest rules of confidence. The fiduciary relationship in matters of private nature is respected to the utmost degree.

Name a competent executor rather than have the state appoint an administrator and dictate the division of your property. As executor of your will, a bank will serve you after your death by serving the best interests of your heirs, or legatees under the will. The existence of a trust department and its ability to perform the duties of testamentary appointments are not dependent upon the life and health of any one man or group of men. You are assured of permanent service, because it will continue to live and perform its duties. If you appoint your next friend or relative as your sole executor, you do not have this assurance. Moreover, he may not have the necessary experience or knowledge for the work, or if he has, he may not be able to spare the time from his business to attend to yours. The trust department of a bank has every necessary qualification of performing duties of trusts.

Absolute Responsibility: Although a man may speculate with his funds during his lifetime, he desires that there be no risk in the proper care of that which he leaves to those dependent upon his bounty. A bank, through its trust department, keeps separate and apart from the assets of the bank, all investments and funds belonging to estates.

What Trust Service Costs: The fees allowed for this particular type of service are controlled by law and cannot in any instance be greater than those allowed to individuals, and in most cases are less. The reasons are several. A bank is, of course, in business for profit, but its primary consideration is at all times "service," and in no branch of its many activities is this more heavily stressed than in its fiduciary capacities. In this, a bank through its trust department serves its customers in the most personal way. A bank is authorized to act by law without bond, which means a considerable saving of time and expense to the estate. Facilities for safe keeping securities and records have already been provided. The outlay for appraisals, clerical help, supplies and other maintenance costs, instead of being charged to one estate, are apportioned among many estates. Moreover, familiarity with administrative details eliminates expensive experiments. A bank naturally carries many "overhead" expenses which an individual executor properly charges against the estate.

Permanent and Always Available: The individual may die; may be away or otherwise unavailable when an emergency might require an immediate consultation by those interested in the estate. A trust department can always be found in the same place every business day. The individual seldom has the proper facilities for exact accounting required by law, and lax methods of administration have often resulted in serious losses. Trust Department methods and systems of accounting must be exact and in full conformity with the requirements of the law. They leave nothing to memory.

In this day and age, very few men are naming an individual as a representative of their estates —as executor. Business men of the country are naming a bank with trust powers—a corporate executor and trustee to act as their representative. This really is the modern business-like way of handling any business matter.

This may start you thinking of—

The Duty of Today: There are certain obligations vital to the future of his family, which every man ought to recognize. There are many cases where the man was going to make provisions "tomorrow," or "next week," or "the first minute he got 'round to it." This man is no less blameworthy than the man who has not considered them at all.

There is no excuse for failure to have a will. This article has been written to clarify, emphasize and urge its importance. The same covers only a few points of general appeal.

These are matters not of tomorrow—*but of today*.

PERIODIC HEALTH EXAMINATIONS AND EARLY DIAGNOSIS OF TUBERCULOSIS*

To procrastinate with tuberculosis is to gamble with death.

Hope of conquering this disease for all time to come, lies in our ability to take action promptly.

The earlier the discovery is made, the more certain the hope of cure.

Details for the conduct of this campaign are given in an attractive "Early Diagnosis Campaign" manual prepared by the National Tuberculosis Association.

The "Early Diagnosis Campaign" is to be a search for that large group of people who have tuberculosis and do not know it yet. Warnings have been shouted from the housetops but physicians still report that most cases of tuberculosis which come to them for their first examination are found to be in an advanced stage of the disease.

The aim of this campaign of the National Tuberculosis Association is twofold, first to focus the attention of the public at large upon the danger signs of early tuberculosis and to urge them to go to their doctor for examination, and second to stimulate renewed interest on the part of the medical profession in recognition of early signs of tuberculosis.

The American Public Health Association, at its annual meeting held in Cincinnati, October, 1927, endorsed by resolution the plan of campaign and offered to lend assistance to the movement. The American Medical Association has agreed to stimulate the interest of the Medical profession through its Journal and to interest the lay public by publishing articles and editorials on the subject in Hygeia.

Throughout Indiana, state, county and city tuberculosis and health associations will organize meetings next month where talks will be given, motion pictures shown and pamphlets distributed, all emphasizing the importance of early diagnosis. The National Tuberculosis Association is preparing several million pieces of printed matter for distribution throughout its affiliated associations. A motion picture for lay audiences to be called "Let Your Doctor Decide" and another for medical groups entitled, "The Doctor Decides" will be used in the campaign. It is expected that 10,000 billboards will carry the message of the campaign.

All medical, health, social and disease prevention organizations, both nonofficial and official, are being urged to participate in this movement as those behind the campaign feel that a united, nationwide effort will help greatly to focus attention upon the necessity of early diagnosis of tuberculosis.

*This article prepared by the Bureau of Publicity of the Indiana State Medical Association and is published at the request of the Bureau. This is the last of a series of four bulletins prepared by the Bureau upon the subject of periodic health examinations.

INDIANA UNIVERSITY NEWS NOTES

The degree, Doctor of Medicine, was given to ninety-one members of the 1928 class of the Indiana University School of Medicine at the ninety-ninth annual commencent at Bloomington, June 11. The degree, Doctor of Medicine, Cum Laude, was given to Wendell Willard Ayres, M.D., 1926, who did graduate work as an interne in the Indiana University Hospitals, 1926-1927, his thesis being "Purpura Hemorrhagica of a Familial Type with Study of a Case"; and to Harold M. Anthony, M.D., 1927, of Muncie, who did graduate work while an instructor in anatomy in the School of Medicine at Bloomington, 1927-28, his thesis being "Pes Planus," and to Charles L. Richardson, M.D., 1927, of Rochester, who did research work while an interne in the Indiana University Hospitals, 1927-28, his thesis being "Chemical Changes in the Blood in Mercuric Chloride Poisoning."

All but four of the 1928 class have already chosen their internships for the next year. Their names and the hospitals where they will continue their medical training follows:

Harold C. Adkins, Indianapolis, Harper Hospital, Detroit, Michigan. Howard Aldrich, Hamilton, Methodist Hospital, Indianapolis. Lewis G. Allbritton, Warrior, Alabama, not decided. Alfredo Ojerio Alonzo, Camalaningan, Phillipine Islands, St. Joseph Hospital, Fort Wayne, Indiana. James F. Balch, Clinton, Indiana University Hospitals, Indianapolis. William E. Ballenger, Economy, Methodist Hospital, Indianapolis. Vincent L. Barker, Connersville, Ford Hospital, Detroit. Theodore W. Benson, Logansport Cook County Hospital, Chicago. Louis Berkowitz, Warren, Ohio, Indiana University Hospitals, Indianapolis. Edward G. Billings, Valparaiso, Indiana University Hospitals, Indianapolis. Thomas E. Broadie, Williamsport, Anker Hospital, St. Paul, Minnesota. Frederick W. Beuchner, South Bend, Epworth Hospital, South Bend. (Miss) Ladoska Lee Bunker, North Manchester, Women and Children's Hospital, Philadelphia, Pennsylvania. John C. Carney, Delphi, Indiana University Hospitals, Indianapolis. John L. Carpenter, Peru, Methodist Hospital, Indianapolis. Russell S. Clymer, Anderson, City Hospital, Indianapolis. Lowell T. Coggeshall, Saratoga, United Fruit Company Hospital, Havana, Cuba. Paul K. Cullen, New Albany, City Hospital, Indianapolis. Carl H. Cunningham, Loogootee, St. Elizabeth Hospital, Lafayette. Robert E. Daniels, Decatur, Epworth Hospital, South Bend, Indiana. Noble Cort Davidson, Zionsville, City Hospital, Indianapolis. Wemple Dodds, Logansport, Assistant Instructor in Pathology Department, Indiana University School of Medicine. John A. Egan, Wabash, City Hospital, Indianapolis. John T. Emhardt, Indianapolis, City Hospital, Indianapolis. Donald W. Ferrara, Gary, Indiana University Hospitals, Indianapolis. Joseph O. Flora, Chili, Indiana University Hospitals, Indianapolis. Richard P. Good, New Point, Starling-Loving Hospital, Columbus, Ohio. Floyd L. Grandstaff, Preble, Indiana University Hospitals, Indianapolis. Hubert Gros, Delphi, Indiana University Hospitals, Indianapolis. Maurice E. Gross, Coatsville, St. Vincent's Hospital, Indianapolis. Harry E. Harkcom, Valparaiso, Uniontown City Hospital, Uniontown, Pennsylvania. Robert F. Harris, Noblesville, City Hospital, Indian-

apolis. Layman Robert Harrison, Indianapolis, McKeesport General Hospital, McKeesport, Pennsylvania. Clayton B. Hathaway, Auburn, City Hospital, Indianapolis. Clifford W. Hoffman, Laurel, not decided. Samuel Hurwitz, Cleveland, Ohio, Good Samaritan Hospital, Cincinnati, Ohio. Roy T. Hynes, Indianapolis, St. Vincent's Hospital, Indianapolis. Albert Tenly Jones, Linden, City Hospital, Indianapolis. David B. King, Anderson, City Hospital, Indianapolis. Oren L. Kirklin, Muncie, Indiana University Hospitals, Indianapolis. Harry E. Kitterman, Fairmount, St. Vincent's Hospital, Indianapolis. Maurice O. Klingler, Garrett, Ancon Hospital, Panama. Isador J. Kwitny, Indianapolis, City Hospital, Indianapolis. C. E. F. Laatsch, Indianapolis, City Hospital, Indianapolis. William F. Leslie, Mishawaka, Queen's Hospital, Honolulu, Hawaii. Robert E. Lyons, Jr., Bloomington, Methodist Hospital, Indianapolis. Charles W. McMillen, Dayton, McKeesport General Hospital, McKeesport, Pennsylvania. Carey R. MacDonnell, Indianapolis, not decided. William D. Mackay, Valparaiso, City Hospital, Indianapolis. William B. Martin, Warrior, Alabama, Hillman Hospital, Birmingham, Alabama. Margaret Hatfield, Indianapolis, New England Hospital for Women and Children, Boston, Massachusetts. Charlotte E. Mason, Sullivan, Hospital for Children, San Francisco, California. Robert D. Meiser, Columbia City, Methodist Hospital, Indianapolis. Elisha A. Metzger, Covington, Indiana University Hospitals, Indianapolis. Fritz M. Meyer, Indianapolis, Guy's Hospital, London, England. Addison G. Moore, Flora, Lying-In Hospital, New York City. M. S. Mount Noblesville, City Hospital, Indianapolis. Eliga B. Nisbet, Madisonville, Ky., St. Louis City Hospital, St. Louis, Mo. T. W. Omstead, Angola, Fletcher Sanitarium, Indianapolis. Guy A. Owsley, Thorntown, Medical Corps, United States Army, Letterman Hospital, San Francisco, California. William E. Pearson, Wabash, City Hospital, Indianapolis. Clement L. Poston, Mays, Methodist Hospital, Indianapolis. Francis W. Pruit, Westfield, Medical Corps, United States Army, Letterman Hospital, San Francisco, California. Frank W. Ratcliff, Kingman, St. Elizabeth Hospital, Lafayette. Russell C. Rees, Knightstown, St. Luke's Hospital, Spokane, Washington. Arthur C. Rettig, Evansville, Indiana University Hospitals, Indianapolis. Lester B. Rhamy, Wabash, City Hospital, Indianapolis. Floyd Riggs, Clay City, Methodist Hospital, Indianapolis. Ray B. Robertson, Ewing, City Hospital, Indianapolis. Emery A. Roventine, Crawfordsville, not decided. Russell A. Sage, Indianapolis, Indiana University Hospitals, Indianapolis. Roy E. Shanks, Lawrenceburg, City Hospital, Indianapolis. Claud E. Skomp, Lyons, St. Vincent's Hospital, Indianapolis. Kenneth C. Smithburn, Noblesville, City Hospital, Indianapolis. Emory B. Smoot, Washington, Harper Hospital, Detroit, Michigan. Andrew E. Soudah, Indianapolis, City Hospital, Indianapolis. Joe W. Sovine, Bunker Hill, Methodist Hospital, Indianapolis. Edward T. Stahl, Kokomo, St. Elizabeth Hospital, Lafayette. Guy E. Stahr, Marion, Medical Corps, United States Navy. Joseph L. Storey, Sullivan, City Hospital, Akron, Ohio. Harry B. Thomas, Bloomington, City Hospital, Indianapolis. Mark H. Williams, Quincy, City Hospital, New York City. Leslie Wilson, Longstreet, Kentucky, Methodist Hospital, Gary. Bruce K. Wiseman, Indianapolis, City Hospital, Indianapolis. Earle V. Wiseman, Winona Lake, Indiana University Hospitals, Indianapolis. James R. Woods, Jr., Swayzee, St. Vincent's Hospital, Indianapolis. Herbert C. Wurster, Indianapolis, United States Public Health Service. Ralph H. Young, Huntington, City Hospital, Indianapolis. John M. Zivich, East Chicago, Cook County Hospital, Chicago. Benjamin A. Zimmerman, Vermillion, South Dakota, Barnert Memorial Hospital, Patterson, New Jersey. Reuben O. Zierer, Batesville, City Hospital, Indianapolis. Gerald M. Kempf, Jasper, City Hospital, Indianapolis.

THE degree, Doctor of Dental Surgery, was given by Indiana University to eighty-four graduates of the 1928 class of the Indiana University School of Dentistry. One of this class, Seth W. Shields, of Brownstown, will serve as dental intern at the James Whitcomb Riley Hospital for Children during the coming year, and assist in dental service of the other Indiana University Hospitals.

THE degree, Graduate Nurse, was given to forty-nine members of the senior class of the Training School for Nurses of the Indiana University School of Medicine. Owing to the fact that classes are admitted twice a year, some of those receiving degrees had completed their work several months before, and others will receive their diplomas after completing some additional work. Three full years of time are required to complete the course, and time lost for any reason must be made up. This was by far the largest class ever graduated. Enrollment in the training school is now approximately 200. The half-million dollar Ball nurses' home and training school, ready for occupancy in August, will provide residence quarters for 165 nurses.

DR. G. J. GARCEAU (A.B., University of Minnsota, M.D., Northwestern, 1924) is the new chief resident in surgery at the James Whitcomb Riley Hospital for Children. Dr. Garceau served one year general internship at the Methodist Hospital, Indianapolis; one year as resident at the Allison Hospital, Miami Beach, Florida; one year as resident at the Shriners' Hospital for Crippled Children, Chicago; five months in orthopaedic surgery at the Carney Hospital, Boston, Massachusetts, and nine months as resident at the Methodist Hospital, Indianapolis.

Dr. J. H. Clevenger, (M.D., Northwestern, 1926) is the new chief resident in surgery at the Robert W. Long Hospital. He served one year general internship in the Methodist Hospital, Indianapolis, and three months in surgery at the University of Michigan Hospital, Ann Arbor, Michigan. Dr. Clevenger succeeds Dr. Kenneth D. Ayres, who is opening an office for the practice of surgery in Anderson. Dr. Ayres received his special training here and in the Henry Ford Hospital, Detroit.

Dr. Charles L. Richardson, (B.S., Indiana University, 1925, M.D., 1927, M.D., Cum Laude, 1928,) succeeds Dr. Howard Allen as chief resident in medicine at the Robert W. Long Hospital. Dr. Richardson served a general internship in the Indiana University Hospitals the past year. Dr. Allen will practice in Indianapolis.

Dr. Marion H. Bedwell (B.S., Indiana University, 1925, M.D., 1927) has been appointed to succeed Dr. James D. George as chief resident of the William H. Coleman Hospital for Women, in September. Dr. Bedwell completed his first year

of internship in the Indiana University Hospitals in June.

Frank C. Mann, M.D., professor of experimental medicine and pathology of the Mayo Foundation, Rochester, Minnesota, was the guest speaker at a seminar conducted by Alpha Omega Alpha, national honorary scholarship medical fraternity, in the auditorium of the medical building at the Indiana University School of Medicine, Friday, May 25.

Dr. Mann, who was graduated from the Indiana University School of Medicine with the class of 1913, has attained international recognition in medical circles for his discoveries regarding the physiology and functions of the liver. He spoke on "The Place of Research in Medicine." The meeting was open to members of the medical profession.

Dr. Mann was recently elected to honorary membership in Alpha Omega Alpha by the local chapter. Active members recently elected on the basis of high scholarship from the junior and senior classes of the Indiana University School of Medicine are: Lowell T. Coggeshall, Saratoga; Dwight L. DeWees, Morresville; Donald W. Ferraro, Gary; Ray B. Robertson, Ewing; Emery A. Rovenstine, Crawfordsville; Kenneth C. Smithburn, Noblesville; and Edward T. Stahl, Kokomo, from the senior class, and Noel S. McBride, Terre Haute; Russell F. Sanders, Centerville; Samuel R. Snodgrass, Franklin; Donald J. White, Indianapolis, and Merle E. Whitlock, Fairbanks, from the junior class.

Dr. Matthew Winters, assistant in pediatrics, presided, and the guest speaker was introduced by Dr. Willis D. Gatch, head of the department of surgery, under whom Dr. Mann began his research studies on the causes of shock while a student here.

Student nurses accepted from probation class of Indiana University Training School for Nurses March 1, 1928:

Doris B. Bunger, Rising Sun; Fern Coy, Noblesville; Irene Cribbs, Shelbyville; Marian K. Fischer, Indianapolis; Helen E. Rice, Crawfordsville; Eleanor Crowe, Charleston, Illinois; Aurelia C. Willers, Lawrenceburg; Gladys L. Nichols, Heltonville; Mary Lindley, Elizabethtown; Mary K. Nash, Princeton; Ruth E. Bard, Brazil; Mabel Deiwert, Greensburg; Jean S. Baker, Marion; Josephine Doup, Columbus; Ruth V. Aikman, Washington; Mary E. Beals, Richmond; Ethel L. Bell, Peru; Wilma R. Boatman, Rosedale; Rachel L. Boland, Muncie; Mary F. Browning, Brownstown; Margaret O. Buchanan, Ladoga; Catherine O. Coffman, Franklin; Mildred M. Coleman, Frankfort; Elfreda DeHart, Farmersburg; E. Waneta Edwards, Kokomo; Marilla Green, Newton; Jessie L. Hobbs, Gaston; Nellie R. Huntington, Ladoga; Lucy E. Little, Columbus; Dorothy L. Mooney, Harmony; Dorothy E. Murphy, Logansport; Ruth Peirce, Delphi; Opal J. Reichart, Mulberry; Anne C. Schwein, Brownstown; Thelma L. Seeger, Lafayette; Sarah K. Stam, Elwood; Thelma R. Stoffer, Mexico; Olive B. Vermillion, Rockville; Geneva V. Thorne, Gaston; Ruth Turnipseed, Lafayette; Mary E. Tinker, Adams; Vivian J. Ratcliff, Crawfordsville; Edna M. Hunnicutt, Greens Fork; Vera M. Clark, Greensburg; Elizabeth K. Hopewell, Carlisle.

Probation students accepted March 1, 1928:

Eliza M. Beals, Richmond; Arzelia H. Brian, Sebring, Florida; Vivian Ziliak, Princeton; Leota P. Elliott, Campbellsburg; Mary E. Elliott, Campbellsburg; Lillie M. Ayres, Nashville; Ruth M. Wills, Connersville; Oneta May Farr, Bloomington; Ruth A. Albert, Liberty; Gertrude Clark, Danville; Nora M. Crafton, Greensburg; Viola D. Hacker, Frankfort; Margaret Kinney, Seymour; Louisa A. Norris, Indianapolis; Nellie B. O'Banion, Indianapolis; M. Katherine Shepard, Franklin; Evah R. Sisson, LaGrange; Karolyn Strickler, Boggstown; Helen Townsend, Bloomington; Elizabeth I. Toombs, Muncie.

C. R. MacDonnell.

ETIOLOGY AND RESULTS OF TREATMENT IN ANGIONEUROTIC EDEMA AND URTICARIA

The experience gained in the study and treatment of 260 cases of angioneurotic edema and urticaria is related by Frank R. Menagh, Detroit (*Journal A. M. A.*, March 3, 1928). No distinction is made between these two disorders. It is assumed that they are the same process, involving in the case of urticaria the superficial layers of the skin, and in angioneurotic edema the subcutaneous tissues. These cases have been classified into two major groups, according to etiology. In one group comprising thirty percent of the series, in which there was entire freedom from biliary tract disorders, the etiologic factors were the absorption of food and other foreign proteins. In the second group, comprising 48.8 percent of the series, biliary tract disease was the only etiologic factor. Observations were made relative to the absorption of bacterial proteins from the biliary tract in these cases. The etiologic factors in 11.2 percent were biliary tract disease and the absorption of other types of foreign protein. Treatment was directed toward the biliary tract when this was involved, and toward the removal of active foreign proteins in those cases in which these proteins were responsible for the symptoms. In those cases in which results are known 16.3 percent were unimproved by treatment, 38.6 percent were improved, and 45.2 percent showed complete relief. In searching for the etiology of angioneurotic edema and urticaria, Menagh concludes that it is necessary to consider absorption from the biliary tract as a possible cause in addition to the usual foreign proteins considered in other allergic problems. When this factor is kept in mind, treatment gives satisfactory results.

A doctor in Milwaukee, in reply to a written demand that a certain patient's bill be paid at once, as it was four months overdue, received the following scrawl at the bottom of the statement, to which the check was attached: "Dear Dr. Sorry. Shld have paid this lst mnth; but wife, in marking up bills to put through chkbk, wrote 'DETOUR' instead of 'DOCTOR'—and I routed it *around* instead of *through!*"—*Medical Pocket Quarterly.*

Buy a Rattle

Dealer (rushing into the newspaper office): "See here, you've published an announcement of my death by mistake. That's got to be fixed up somehow."

Editor: "Well, we never contradict anything we have published, but I'll tell you what I'll do. I'll put you in the births column tomorrow and give you a fresh start." —*Good Hardware.*

Heavens!

"What a charming baby! And how it does resemble your husband!"

"Gracious, I hope not! We adopted it!"—*Pennsylvania Punch Bowl.*

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Editor and Manager

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JULY, 1928

EDITORIALS

ACUTE PANCREATITIS

Sir Berkeley Moynihan, Bart, noted English surgeon and president of the Royal College of Surgeons of England, has published a series of addresses on surgical subjects in which he expresses very definite ideas concerning various phases of abdominal surgery, and a wider dissemination of his views seems justified. We therefore reproduce a part of what he has had to say concerning acute pancreatitis, the most terrible of all calamities that occur in connection with the abdominal viscera. The suddenness of the onset of the disease, the illimitable agony which accompanies it, and the mortality attending it, all render it the most formidable of catastrophies. Moynihan says that "the clinical picture presented by an acute case of pancreatitis is quite unmistakable. It is because the surgeon omits to think of this disease that its presence escapes him. The first and chiefest condition is pain, and of all the pains the human body can suffer this is by far the worst. The pain is so intense that it causes profound collapse in which the pulse rises rapidly and loses volume and the blood pressure falls. The patient is prostrate, faint and pallid; the pulse may be hardly perceptible; the limbs and face are cold, and death itself seems imminent. No such state is seen in any other form of casualty. There is all the collapse that even the greatest hemorrhage could cause, and more than the agony of a visceral rupture. Corroboration of a diagnosis made upon these evidences alone is hardly necessary; but if it were it is never lacking. Vomiting is almost invariably present, and it occurs early. There are cases in which it is repeated with great frequency and severity, so that the resemblance to a case of high intestinal obstruction, in respect of this one symptom only, is very close. The face is livid, and patches of a slate-blue color may be distributed irregularly over the surface of the abdomen, or even of the limbs. This cyanosis is never found in other forms of acute abdominal catastrophe; it is not always present in acute pancreatitis, but if it is found, it is an undeniable evidence of acute pancreatic disease. An examination of the abdomen makes the diagnosis still more certain. There is a degree of rigidity in the whole abdomen, and the epigastric region is certainly a little firmer than the rest. The whole abdomen is tender, but the tenderness is more acute above the umbilicus than below, and often is far more exquisite to the left of the middle line than to the right, a point not without significance.

"The differential diagnosis in cases of acute pancreatitis should present little difficulty. The more acute the case the easier is the recognition. No other catastrophe within the abdomen produces at once such unendurable agony and so profound a collapse. Intraperitoneal hemorrhage, resulting from a ruptured gestation, causes intense prostration, blanching, loss of volume in the pulse with increase in its rate, but relatively, the pain is almost negligible, and the site of it is different.

"There can be no doubt that recovery from acute pancreatitis, of all grades, except the most severe, is possible without operation. In a number of cases in which I have operated for stones in the gall-bladder, or in the common duct, very extensive areas of fat necrosis have been found, and the pancreas has been large, infiltrated with blood, and oedema around it has been considerable. It is, however, equally certain that recovery from this disease, apart from operation, is so rare that no case should be left untreated. Not all the operations that have been practiced have helped in the recovery of the patient, for a few instances are related in which the abdomen was opened, the diagnosis made, and the wound closed without anything more being done. Recovery in such circumstances would probably have occurred if the patient had been left alone. The diagnosis is almost invariably made before the operation commences. In the fat of the abdominal wall, areas of fat necrosis may be seen before the peritoneum is opened. As soon as the abdominal cavity is reached blood-stained fluid escapes. Whatever doubts may have been previously felt as to the nature of the disease, they are at once resolved when these two conditions, fat necrosis and sanguineaus exudate, are found. In a very large proportion of the cases a great but local dilatation of the transverse colon below the pancreas is found. The colon here is not only much larger than either the ascending or the descending colon, but it is congested in appearance, sometimes very deeply congested, or even inflamed. The condition of the pancreas and of the parts around varies very much. In the most severe cases the pancreas is a phlegmon filled with blood, deep purple in color, looking ready to burst. In the less severe cases, hemorrhage into the gland is only slight and patchy, and a little turbid blood-stained fluid is found either in the lesser sac or behind its posterior layer. The isolation of the pancreas at this stage is very important. The fluid about the pancreas is extremely toxic, and its escape into the general cavity of the peritoneum, followed by its absorption, might gravely affect the result of the operation. A dread of this result has influenced many surgeons in their refusal to incise the posterior layer of the

lesser sac, and the capsule of the pancreas. It is a mistake not to give vent to this exudate; it can be evacuated without any risk, if adequate care is taken, and after all absorption is more likely to take place from the pancreas itself, or from the cellular tissue around it, if this fluid is allowed to remain under great tension. Incision of the pancreas itself need never be made. If the gland feels very oedematous and soggy, the finger may be very gently insinuated into it here and there, so as to make points of escape for retained secretions and blood. Drainage must be free. In a week or ten days after operation a copious discharge of a dirty-looking, turbid, blood-stained fluid with sloughs, large and small, may occur. Displacement of the rectus to the outer side will do something to prevent the development of a hernia subsequently. If a hernia develops it can be repaired; if drainage is not adequate the patient will die.

"The question as to what shall be done in respect of the gall-bladder will depend upon two considerations: the general condition of the patient, and the state of the gall-bladder itself. Whatever the condition of the patient may be, if stones are present in the gall-bladder or common duct, a tube should be placed in the gall-bladder, as many stones as possible being removed from them both. The complete emptying of the gall-bladder, or its removal, may be left to another day, but a drainage tube in the gall-bladder will allow the escape of bile and prevent any great pressure within the ducts. If the patient's condition permits it, complete evacuation of the stones should be possible; or in the most favorable circumstances, cholecystectomy may be considered safe. The margin of safety must not be overstepped. The surgeon is operating to save a life in jeopardy; not to cure his patient of cholelithiasis. If the patient is very ill, and very stout, having a gall-bladder shrunken and fibrotic, buried in adhesions and inaccessible, it is safer to leave matters alone."

THE PHYSICIAN'S VACATION

This is the time of the year when every physician should think about taking a vacation, for it is the one season when outdoor recreation is possible with the least discomfort from weather conditions. It seems like idle talk to say anything about the necessity of a vacation and yet we know, through conversation with many physicians, that only a small percentage of the members of the medical profession really take vacations that are needed as a tonic to boost a flagging ambition. We actually know some physicians who haven't taken more than a day from their offices in the last ten years, and some of them for even longer periods of time. A few physicians even brag of the fact that except for sickness they haven't missed a day from practice for many years, and we think that they should be ashamed to make such a boast. In fact, we venture the assertion that such men not only have lost much of the interest and incentive that should prompt one to stay in the medical profession but they have fallen back in the procession and are not what may be considered as progressive men. Every person, no matter what his trade or profession, is benefitted by an occasional change of scene and surroundings. Some consider that a visit to a nearby city or even a day's fishing at a nearby lake is vacation enough, but we contend that the most benefit comes from a vacation that is taken far from the scene of active work, and with no thought of the work back home. People may differ as to what constitutes recreation, for one man may like hunting, another fishing, another automobiling, another traveling by water, and still another golfing, but whatever the recreational hobby may be, that hobby should be indulged at least once a year for a period of anywhere from two to six weeks, and during that time the hobby and nothing but the hobby should take up his mind. Our own preference is for outdoor recreation like camping and fishing, sufficiently far from civilization to insure quiet and rest to say nothing of good fishing, and during the two to four weeks so employed an effort is made to keep all thought and conversation away from every phase of the practice of medicine. At the end of such a vacation one returns to his work refreshed in body and mind, and capable of doing more and better work than has been possible for weeks prior to the vacation period. We have little sympathy for the man who thinks that he cannot get away from his practice, for no physician is so busy that he cannot take the time for the rest and recreation that is necessary to keep him in the best physical and mental condition. Furthermore, if any physician has such a poor hold upon his patrons that he cannot retain their patronage even though he takes an occasional much-needed vacation, he certainly isn't worth much as a practicing physician and he had better seek some other occupation. Right now the ocean, lakes, streams, and even the golf links are calling you. Some time during the summer season pack your grip for an ocean voyage or a trip around the Great Lakes, or crank up the "flivver" and go away to see an interesting part of this great country of ours, or better still, get out your fishing tackle and start for distant lakes and streams, away from civilization and where fishing seems to be best, but above everything else —*Take a Vacation!*

MILBANK HEALTH DEMONSTRATION

We have been believing that the public is paying the penalty for its recognition and patronage of some of the uneducated and untrained members of cults and of medical pretenders of various types, but we are wondering if welfare workers, and particularly those who are dabbling in public health matters, are not a greater menace to

the general good of the body politic? Certain it is that some of the welfare organizations are taking a very active hand in the shaping and control of public health measures, and as a mere side issue are taking a very vital interest in the management of individual health. A much vaunted half-million dollar health demonstration inaugurated five years ago in one of the counties of New York State and financed by the Milbank Memorial Fund, not only has been a failure, but has received the very just condemnation of the medical profession. It has been pointed out to the New York State Medical Society that the Milbank health demonstration, at considerable expense, has been conducted by practitioners unlicensed in the state of New York, thus breaking the laws of the state; that nurses of the demonstration have practiced medicine in violation of the laws of the state; that employees of the demonstration have made disparaging remarks concerning the medical profession as a whole and the competency of the physicians residing in the county where the demonstration was inaugurated; that this welfare organization deliberately created and organized public sentiment for its own benefit, and made no effort to ascertain medical professional opinion nor to secure professional support. The attitude of the enterprise toward the medical profession has been one of persecution and even abuse, and the effect upon the public has been to create or stimulate dependency and pauperism.

It seems to have been proved that this Milbank demonstration, represented by a county health unit composed of four laymen and one physician, and employing physicians of questionable education and training, has been a failure. As one writer says, "the quality of service has been pitiable, and every physician in the county has been face to face with a daily demonstration that social service cannot compete with the individual skill and superior knowledge and efficiency of the trained and capable practicing physician." He goes on further to say, "A few days ago I received from one of the Milbank clinics a card showing the results of their examination of one of my patients who had been guided to their portals by the ubiquitous health nurse. The examination was made hastily, as all such examinations must necessarily be, the attempt at diagnosis was laughable, and the accompanying x-ray portrait was obviously the pathetically inadequate work of some stenographer or office boy. Such inefficient clinical work merely makes the demonstration the laughing stock of any qualified practitioner however solemnly taken by the untutored public."

Is it any wonder that the medical profession, thinking far more of the good of the public, offers a protest against such quackery? Some of the money used in this health demonstration was wrested from the taxpayers of the county. Most of it has been wasted, and the public has suffered from inadequate and inefficient service and a lowering of the morale of the sick and suffering. What has occurred in New York is going to occur in every section of the United States unless the medical profession takes a firm hand to suppress it. The cry of the welfare workers is that public and private health is purchaseable and may be furnished on the mass plan through the organized efforts of such enterprises as that which failed so lamentably.

The lessons learned from this New York experience point the way to a solution of the problems before us. First, physicians must assume the leadership in organization and management of public health activities. The work cannot be efficiently and well done by lay organizations nor should lay organizations be permitted to attempt it. Second, physicians, and particularly the younger physicians, should refuse employment at meager salaries by lay organizations that would prostitute the profession to commercial ends. The ruthless exploitation of the younger physicians by welfare organizations must cease. Third, the activity of the over-zealous, full time salaried lay social worker, and so-called health nurse, who ransacks the highways and byways to find recruits for the so-called health clinics, must be suppressed, not only because of the inadequate and inefficient service rendered the public, but because it is in direct competition with the educated, trained and thoroughly qualified physician who, unless protected, must perforce soon belong to a vanishing class.

FREE CLINICS AT CHAUTAUQUAS

THE Indiana State Medical Association has been asked to sponsor Child Health Week at the Winona Lake Chautauqua, July 9 to 13, 1928. According to the program, one of the features of the five day meeting will be a free clinic for babies and pre-school children. We are unalterably opposed to these free clinics given under the auspices of the State Board of Health, public health nurses, the paid agents employed under the patronage of the Sheppard-Towner Act, or any other welfare agencies. We have no objections to the health lectures by physicians, exhibits, and motion pictures on maternal, infant and child care. However, the free clinics, furnished with material secured by ransacking the country far and wide, and open to rich and poor alike, is a species of paternalistic or socialistic medicine which does not deserve the endorsement of the medical profession. Furthermore, these free clinics would almost "die aborin'" were it not that a certain number of reputable physicians give gratuitously of their time and talents in making examinations and giving advice, and just why any members of the regular medical profession should be roped in on any such paternalistic scheme is a question that defies logical solution.

RELATION OF PHYSICIANS TO PUBLIC HEALTH

IN discussing the question of the relation of physicians to public health, Dr. Harlow Brooks, of New York, before the Cattaraugus County Medical Society, of New York, had some very pertinent things to say concerning lay control of medical activities, and the pernicious influence of certain social workers who, if they had their way about it, would turn the country over to State Medicine. Dr. Brooks says:

"I know few rascals in the medical profession. I know few men in it who do not value their professional standards as high as life itself. I know few doctors who do not try to keep abreast of the times. I know few doctors who die rich. I know many doctors who devote their time as employees of business institutions; some of them are men of considerable capabilities but they have been dwarfed and curtailed by business control. Few of them frequent the libraries or medical societies. Eventually they become worth no more than the salary they receive. They are the result of the vaunted 'business control of medicine.' Many of them devote their time as secretaries and agents of organized charities. They are despised by their employers, who would never trust them with their lives; they are useless to the profession, and they eventually become so 'organized' that they might as well be classed merely as lay secretaries.

"What does the physician in family practice resent in the activities of public health? He resents nurses doing the work of a physician, making diagnoses, and dictating treatment that the family physician should carry out. Do you blame him? He resents the underpaid, time-serving employee of the department, who from the wealth of his inexperience, minimizes to school children the work and ridicules the respect of their family doctor. He resents wholesale *septic* vaccination and other evidences of legal but bad practice. He resents snap diagnoses in cases to which he has perhaps given serious, experienced and intelligent study. He resents being directed to give treatments which he knows to be still in the experimental stage. He often has just cause for his complaints, because he knows himself to be the better man. This is all correctible. Nurses are nurses until they have studied medicine and legally qualified themselves as practitioners of medicine. They should not be allowed to do, as an agent of public medicine, work which the law does not permit them to do as private individuals. . . .

"Public medicine cannot be divorced from private medicine except at a loss to both. The most potent and influential teacher of public medicine is the physician in contact with his patient. No public medicine can succeed that has not had the endorsement of the average physician. . . . We of the medical profession believe that a license to practice should be granted only after four or more years of study in an accredited school, superimposed on a preliminary education of no mean extent. That this idea is not held by the public at large is only too visibly shown each year by all manner of cults, often backed by the clergy, well-intentioned philanthropists, financiers and people of all sorts, intelligent and otherwise . . .

"Let us, through our state and county societies, enlist every doctor in the work of public health. Let us invite the co-operation of every honest lay body, but we must dominate. And we must insist that the professional standards which have made medicine shall still prevail, and that medical science shall control medicine in all its applications. Let us take over the city and county health organizations—too many of them are now taking us over. But we must demand that only the competent shall rule. We must demand that at all times the traditions and ethics of medicine shall be respected."

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you*.

WHAT has happened and is going to happen to the heart muscles of the marathon dancers? Why permit such idiotic exhibitions anyway, and why encourage a feat that brands those engaged in it as being little short of imbeciles?

BEGIN making preparations for the annual session of the Indiana State Medical Association to be held in Gary, Wednesday, Thursday and Friday, September 26, 27 and 28. If you have not engaged your hotel accommodations do so right away. Headquarters will be at the Hotel Gary.

HEREAFTER the state medical associations will know whether their American Medical Association delegates have been playing golf or attending the meetings of the House of Delegates as required through official position. A record of attendance is to be published. Some of the delegates are squirming, but then—"Duty before pleasure."

SOME physicians seem to take special delight in rolling the word "acidosis" over their tongues. When they can't think of anything else as the cause of the trouble they are reminded that they

can fall back on "acidosis" or "toxemia" and get away with it when talking to the average layman. Acidosis as the cause of some of the complaints of our patients is greatly overworked.

WHILE returning from the Minneapolis session of the American Medical Association a genial gray-haired old lady, wife of a prominent physician, handed us a piece of poetry which reads as follows:

"Mary had a little skirt,
It was so light and airy!
It never showed a speck of dirt,
But, my! How it showed Mary!

IN New York State the auto fatalities increased over thirty per cent for last year. *Health News* says that while the report does not so state, it is probable that some of these people, at least, failed in the exciting game of trying to beat the train to the crossing, and the question is asked, "How long will communities wait before starting active traffic study and instituting effective methods of control of automobile driving?"

THE resolution calling upon the Judicial Council of the American Medical Association to investigate the subject of free medical service to students in universities and colleges, irrespective of the ability of the individual to pay for the services, apparently did not receive favorable consideration at the Minneapolis session. What are we afraid of, anyway? Is free medical and surgical service to the son or daughter of a millionaire justified by any rules of logic or reason?

A garrulous female dietitian who talks gliby about calories and the value of certain foods in maintaining the highest perfection of health, was recommending a special diet to reduce overplumpness in women and to give that sylph-like form so much desired by most members of the female sex, when she is reported to have said, "Ladies, if you will follow this diet you soon will become quite syphilitic." Perhaps she was trying to coin a new term, but "syphilitic" will hardly pass.

WE recently learned that a man in one of the smaller towns of the State of New York positively refused to be vaccinated or permit any member of his family to be vaccinated as protection against smallpox that was prevalent in the adjoining county. Practically all the rest of the community submitted to vaccination. Subsequently he and two members of his family were the only ones in the community to contract smallpox. Rather a severe penalty to pay for ignorance and cussedness!

PERIODIC health examinations still are being advertised as being performed by members of the various cults. It strikes us as decidedly humorous to read the advertisement of a chiropractor who says that it is now recognized as being necessary to have an inventory of one's physicial condition at least once a year, and that the one to give it is a chiropractor. Well, perhaps in the particular locality where this chiropractor holds forth the regular physicians are neglecting to make physical examinations and, if so, it is no wonder that the public takes up with a pretender.

DUE to a vigorous advertising campaign the public has obtained the idea that yeast is good for whatever ails you. It is fortunate that the United States Public Health Service is giving this matter some attention and already has issued a statement to the effect that the value of yeast in the treatment of various diseases is a subject of controversy which, when finally settled, probably will indicate that yeast will operate more as a corrective of faulty diet than as a strictly medicinal agent. At all events, the use of yeast as a cure-all is greatly overworked.

THE success of the Council on Pharmacy and Chemistry of the American Medical Association, one of the most valuable enterprises ever inaugurated and financed by the American Medical Association, depends entirely upon the support of the individual physician. Dear reader, just how much support are you giving the Council? If you follow the Council's findings and recommendations we take our hats off to you in deference. If you do not follow the Council, we pity you for your ignorance and your failure to protect your own as well as your patients' interests.

WE are rather proud of the fact that at last a medical man has shown some evidence of being a good business man and created for himself a reputation for business system and proficiency. He was a good practitioner of medicine until he voluntarily quit when he found that his business talents could be used to better advantage. His name is Hubert Work, ex-president of the Americal Medical Association, Secretary of the Interior under Coolidge, and recently selected as the national chairman and leader of the Republican party in the campaign of 1928.

THE American Medical Association has gone on record as asserting that the practice of medicine is not the proper function of a corporation, and that the Association will use its utmost endeavors to stop such a growing abuse. This may hit some of the welfare organizations and we hope it does! At last the great body of American physicians represented by the American Medical Association is taking notice of a real peril that threatens the economic and professional standing of the individual practitioner of medicine.

A PHYSICIAN, representing himself as being a member of the Indianapolis Medical Society, is traveling over Indiana attempting to sell a device of questionable merit for the treatment of genito-urinary infections. The apparatus sells for a fancy price, but the point of this comment is to inform our readers that the physician to whom we refer is *not* a member of the Indianapolis Medical Society and bears a questionable reputation. It is just as well to require credentials of strangers who are offering to sell you something, and, anyway, it is just as well to be on your guard to avoid "buying a gold brick."

THE American Medical Association has honored itself when it elected M. L. Harris, of Chicago, as president for the coming year. No man in the profession has done more and perhaps as much constructive work for the American Medical Association and the medical profession in general than Dr. Harris. He is noted as a surgeon, and has furnished some valuable contributions to surgical literature. He also is the author of a number of valuable articles on medical economics. It is men who do constructive work for the medical profession who deserve to be honored, and that is why we are pleased to see the medical profession honor M. L. Harris, of Chicago.

NOTWITHSTANDING the fact that the Board of Trustees had reported that Minneapolis could take care of those who attended the American Medical Association session, there was some complaint concerning failure on the part of the hotels to take care of all of the visitors, and some physicians were obliged to accept accommodations in boarding houses and private homes. In reality everyone attending the American Medical Association session likes to be located in a hotel, and to be shunted off to boarding houses and private homes is unsatisfactory. The attendance at our American Medical Association sessions justifies the selection of places having adequate accommodations, and that means only a few places in the United States, so why fool with any others?

SOME of the health nurses in Michigan are a thorn in the flesh of physicians, inasmuch as they seem to take special delight in steering patients to the free clinics whether the patients are able to pay for the service or not. Well, here in Indiana we occasionally hear of something analagous, though so far as we know Indiana is quite free of many of the socialistic tendencies in medicine that have grown to alarming proportions in many other states. However, we wish to offer this solemn warning to Indiana physicians, and that is that they must be ever on guard if they are going to prevent the establishment in Indiana of some of the evils that have made many other localities undesirable for the practice of medicine, and have made it impossible for the public to secure the best results from medical service.

AT the Minneapolis session of the American Medical Association the question of encouraging medical schools to adopt policies that will make it possible for medical students to graduate and enter practice at an earlier age than at present was discussed. In reporting on this the committee offered its approval and suggested that a plan be adopted whereby the entire medical course could be concluded in three years of four quarters each instead of in four years of three quarters each as at present. They also commented on the fact that the medical course is overcrowded with details, with detailed consideration of the specialties, and that the course could be greatly improved if less crowded and more attention given to essentials and fundamentals. We hope that the medical institutions of the country will pay attention to the recommendation.

AGAIN we desire to object most emphatically to the practice of some hospitals in making show cases or offering for exhibition private maternity cases or other cases that may seem interesting but the very nature of which makes their position embarassing to an audience of whatsoever nature. This idea of making private maternity cases in a hospital the subjects for exhibition for several interns and student nurses is bad enough, but recently we have learned that two interns brought their "best girls" in, with nurses' gowns on, to witness a labor case that was a private case paying the regulation fee for surgical and hospital service. It is time to call a halt on this lack of regard for the finer feelings of many patients in our hospitals, particularly when those patients are paying for privacy and deserve what they pay for even though not granted it on the grounds of common decency.

BOTH the Democrats and Republicans have put prohibition planks in their platforms, but both know that those planks are meaningless. It is reported that both conventions were "dripping wet," and that alcoholic beverages flowed like water at both Kansas City and Houston. In fact Arthur Brisbane, the columnist, is authority for the statement that the hotel bell boys in Houston openly published a statement in the daily papers to the effect that a supply of 36,000 bottles of whisky procured for those attending the Democratic convention was running short and that in accordance with the rule of supply and demand the price would be raised. In many respects prohibition is a farce, and the failure to enforce it has resulted in a crime wave that has been unprecedented. Prohibition has not been enforced because the people, and especially the politicians, do not desire to have it enforced. The whole situation is a beautiful example of hypocrisy.

THE next session of the American Medical Association is to be held in Portland, Oregon. We hope that the facilities are adequate, and no doubt they are, as both Portland and Atlantic City were endorsed by the trustees after due investigation as to qualifications. It has been only five years since the association met in San Francisco, so the Pacific Slope can consider itself fortunate in getting another session of the American Medical Association within such a short period of time. However, the medical profession beyond the Rockies is a progressive one and represented at the present time by a large increase in numbers over what it was five years ago, so it deserves frequent recognition. Then, too, a Pacific Coast meeting gives many eastern men an opportunity to get acquainted with a section of the United States that they perhaps would not visit if they did not have the excuse of a medical meeting to take them there.

"DRUGLESS therapeutic agents such as the x-rays, radium, the various agents used in physiotherapy require as much skill and training to insure their proper use as drugs do, and in the hands of incompetents who have not a standard medical training, are capable of as much harm as drugs prescribed by incompetents.

"It is said on very good authority that many chiropractors are not limiting themselves to drugless methods but are actually employing medicinal agents. This charge has been alleged by the proprietor of a very prominent school of chiropractic who ought to know. He claims that graduates of the institution are drifting from the original purpose of the school. Of course, the various cults adhere for a time to the tenets of their schools, then eventually endeavor to enter the legitimate field of medicine by the back door." —*Journal Michigan State Medical Society,* June, 1928.

ONE of the prominent women actively interested in the promotion of the Woman's Auxiliary of the American Medical Association, reported at the Minneapolis session of the American Medical Association that she had discovered that in her state there were a number of women's clubs that innocently had accepted the invitations of chiropractors to address the clubs on various phases of public health, with a particular relation to the part that chiropractic should play in alleviating the ills of mankind. Very naturally we arrive at the conclusion that the Woman's Auxiliary can do a valuable work if it does nothing more than influence women's clubs to get their information on health matters from members of the regular medical profession. Another leader in the Woman's Auxiliary reported that it was only through the efforts of the women connected with one of the prominent auxiliaries of her state that several women's societies were prevented from endorsing the Sheppard Towner Act and the obnoxious bill that is now offered as a substitute.

WELL, well! Great applause followed the speech of President Jackson when he addressed the House of Delegates at the Minneapolis session of the American Medical Association concerning the fact that the American Medical Association and not an outside organization should undertake the classification of the hospitals of the United States and lay down rules and regulations for their guidance. The editor of THE JOURNAL is a fellow of the organization that seems to be dictating to hospitals as to how they shall be run, but he is of the opinion that the great American Medical Association, representative of the entire medical profession, should take more of a hand in this standardization of hospitals rather than leave the entire matter to a select and self-appointed few who use no better judgment than anyone else in passing out certificates of merit. In fact there has been too much juggling of the list of approved hospitals by the self-appointed censors, and a change of dictators will prove a blessing.

BOTH of the leading political parties have placed a clause in their platforms calling for enforcement of the prohibition act. Both parties know that those clauses mean nothing, and in fact as much can be said for all of the other clauses. It is questionable if anyone except a politician ever read any political platform through from beginning to end, and we doubt if all the politicians do it. It is men and not political parties that count, for it is men of character that usually promulgate, endorse, and put into effect policies that for the most part are good for the public in general. In Indiana we have witnessed such an exhibition of rascality on the part of the political party in power that we don't believe a platform by that party counts for much, and the cry of "Put the rascals out" will not fall upon deaf ears altogether. However, the party ticket, with its meaningless platform, will appeal to the dyed-in-the-wool Republican or Democrat and thus we go on sustaining inconsistency and inviting further disaster. A new deal in this country that would bring about greater respect for our laws and our institutions would be of distinct value to the people. As good citizens, physicians ought to cut loose from affiliation with any one political party and vote for the candidate for office who offers the most promise of giving us relief from existing conditions.

THE Michigan commissioner of health says, in an article in the June issue of the *Journal of the Michigan State Medical Society,* that the most troublesome problems his department has to solve in giving laboratory service are those that arise out of medical ethics. Those problems are just

as much in the foreground with the private laboratories, though there is not the same tendency to demand information concerning paid work that is made upon a state laboratory that furnishes gratuitous service. We observe that the commissioner of the Michigan State Board of Health has taken a very justifiable stand to the effect that no information will be furnished to any one but the physician who sends the specimen for examination, and if to be furnished to others it must be upon the request or permission of such physician. This obviates a lot of unfair criticism and venting of personal spites or antagonisms, as it also prevents many misunderstandings that might occur through the connection of more than one physician with an individual case, or for that matter the relationship existing between patients and attending physicians through the dissemination of knowledge that should be kept confidential. The reports concerning laboratory findings should be considered as privileged medical communications, and copies of the reports should be denied lay persons, health nurses, social workers, and even physicians who have secured the case through a change of doctors.

WE are proud of THE JOURNAL'S advertising pages. We believe that the advertisements are read, but for those who may have been careless in going through the June number we desire to reproduce here an announcement which we carried in the advertising pages and which is as follows:

DON'T BUY GOLD BRICKS

The publishers of this JOURNAL believe the readers have a right to trust the advertisements as much as editorials and news.

Therefore, we are careful to investigate the firms and their copy before we make contracts with them.

We will not accept advertisements of medicinal products that are not approved by the Council on Pharmacy and Chemistry of the American Medical Association. Nor will we knowingly print advertisements of any nature that are not believed to be entirely reliable.

We want every reader to say: "I saw it advertised in my own State Medical Journal and I can safely purchase and prescribe it."

These facts being true, our subscribers should, other things being equal, give preference to the firms, goods and institutions advertised in these pages. All our advertisers are in the A1 class. They want your patronage and it should be a duty, as well as a privilege, to buy from them.

The lumberman who bought a "gold" brick prided himself on the fact that he never read newspapers. Read the advertisements in this JOURNAL. Don't buy "gold bricks."

OF all of the crimes that call for redress none are more important than those connected with our present system of accepting so-called expert medical evidence and especially that pertaining to insanity. A striking example of the misfit of so-called expert testimony is the case of the bootlegger Remus who recently has been released from charges of having murdered his wife. One minute the courts announced him insane following the testimony of so-called expert alienists, and the next minute the courts pronounced him sane due to the testimony of other so-called expert alienists. Whether sane or insane Remus admittedly killed his wife and he should have been punished to the full extent of the law for the murder no matter what the condition of his mind. Another shining example of the miscarriage of justice as a direct result of so-called expert medical testimony is the case of Hickman, the murderer in California. He confessed that he committed the crime, and it was of such an atrocious nature that he should have been hung for it and very promptly. We shall not be surprised if within a few months he goes scot free, and so-called expert medical testimony will do the trick. The Thaw case is still another example. Ye gods! Will we ever have a change in court proceedings so that there will be less miscarriage of justice as the result of the testimony of medical men? Furthermore, God speed the hour when physicians will not bow their heads in shame as they do now when the value of medical testimony is under consideration.

INDIANA had only eighty-four physicians registered at the Minneapolis session of the American Medical Association. Considering the nearness of the meeting place the record does not speak well for the profession of our state. Far off California had a registration of 127, Texas 116, Ohio 159, New York 193, Missouri 140, Nebraska 114, Pennsylvania 152, and even Oklahoma had 60. Of course, the nearby states like Minnesota, with a registration of nearly 1500, presented the largest registration. However, referring to Indiana we are a little embarrassed to acknowledge that we made such a poor showing. Certainly Indiana is just as progressive as any of the other states mentioned, and with the exception of New York and Pennsylvania we have numbers that balance the others. Attendance at the American Medical Association session is in reality a postgraduate course, and there is nothing like it in the whole world. The scientific exhibit alone is worth the time and expense of attendance, even if not a single scientific paper or address were heard. A large number of the rank and file from every state should be interested in the American Medical Association and its activities. Furthermore, a large number of physicians should be interested in taking the *Journal of the American Medical Association,* the largest, best and most influential medical periodical in the world. Fellowship in the American Medical Association, costing five dollars, entitles the fellow to subscription to the *Journal of*

the American Medical Association. What a wonderful return for so little money!

MANY hospitals have discontinued the practice of permitting interns to make emergency calls outside of the institution, even in the immediate neighborhood of the hospital. The *Atlantic Medical Journal* asks if a hard and fast adherence to this rule is always in order? A recent occurrence is mentioned as apropos. A physician living in the immediate neighborhood of a hospital which he frequented, was ill, and his wife, a graduate nurse, thought he was dying. She telephoned the physician in attendance, who lived a considerable distance away, of her fears, and he started immediately to respond to the call. The wife, realizing that her husband was passing away and hopeful that immediate aid might ward off the fatal issue, telephoned the hospital in question requesting that an intern be sent immediately. She states that she was abruptly informed, "It is against orders." When the physician in attendance arrived he found the wife with her arms around her beloved dead, shrieking in the insanity of her grief, "They said it is against orders. They said it is against orders."

We quite agree with the *Atlantic Medical Journal* that the request made for a dying physician, or for any other dying person for that matter, should have been met with immediate response and not the flat statement, "It is against orders." We sometimes feel that there is altogether too great a tendency on the part of some hospitals to measure their service and the spirit of helpfulness with which they serve with a short yardstick.

WE are sorry that the proposition of the Physicians' Home, Inc., as offered to the American Medical Association at the Minneapolis session, was not turned down definitely and finally. In view of an impassioned appeal on the part of its sponsors, made before a committee of which the editor of THE JOURNAL was a member, it was decided that in all fairness the association should analyze the investigation made by the two contending parties and report at the 1929 session of the association. The sponsors for the Physicians' Home, Inc., offered a gratuitous insult to the officers of the American Medical Association when the report of the latter was discredited even though there is every evidence to show that the investigation and report were thorough and impartial. To our notion the sponsors for the Physicians' Home, Inc., have "a white elephant on their hands" and they are anxious to get rid of it and they think that the American Medical Association is about the only "easy mark" that can handle the proposition. We do not believe that there is any crying need for such a home as seems to have been established, and, furthermore, we do not believe that indigent physicians would be satisfied or happy if taken away from home surroundings. Finally, the question of caring for the indigent physician is a matter of concern to the individual community, and we do not believe that any indigent physician will be permitted to suffer as long as he has confreres who are acquainted with his ethical position in the medical profession and can determine that he is deserving of favorable consideration.

WE know of innumerable instances where patients have asked physicians for a bill at the time of receiving services and been met with the answer, "Oh, never mind now, I will send you a bill in due season," and then never paid any attention to the matter for a year afterward, notwithstanding repeated requests from the patient for a statement. We even know of instances where very good and desirable patients have refused to patronize certain physicians because those physicians were careless in business methods. It is time that medical men, one and all, learn that the practice of medicine is a business as well as a profession, and that the majority of people like to patronize a physician who conducts his practice in a business-like way. There is no excuse for not presenting monthly statements, for presentation of a monthly statement does not mean that the physician is urging the patient unduly to pay the account, but the patient has a right to know promptly the amount of his account and, on the other hand, the physician has reason to expect prompt payment consistent with ability to pay. For every patient that seems to be offended by the receipt of a bill on the first of the month following the rendering of service, a dozen other patients will approve such a policy and be more loyal to their physician than ever. Any number of people in every community pride themselves upon maintaining excellent credit by the prompt payment of bills and who actually are peeved when the family physician is so careless and indifferent concerning obligations.

THE well-known firm of Parke, Davis & Company announces that in a few weeks it will inaugurate a policy of general advertising in a number of popular magazines. The firm says that it will not in any sense encroach upon the physician's prerogative and that although the new policy is planned to enlarge the scope of the service of the firm, it is not the intention to deviate one iota from a rigid code of ethics. We hope that a firm that for so long has held the patronage and respect of the entire medical profession will not follow in the footsteps of some other pharmaceutical houses and gradually drift into the practice of soliciting lay persons to be self-prescribers. We know that the temptations to cater to lay patronage is strong, and many, many years of endorsement of Parke, Davis & Company products would make it an easy matter to place those

products direct to the laity. However, we have such a high regard for the ethics of the firm as to believe that this new policy, with its appeal to the public, will not in the future, even though it does not at the present, offend the sensibilities of members of the medical profession. The initial advertising will emphasize the importance of getting medical advice from physicians, will preach the doctrine of periodic health examinations, tell the story of medical science and the contributions the profession has made toward the prevention of disease. The dangers of self-medication will be specifically pointed out. Insofar as this goes the advertising will be of signal importance and value in the promotion of good sound health education. Let us hope that all future advertising will follow along the lines indicated by the initial advertising in lay periodicals.

While discussing the subject of asexualization at a medical meeting, a prominent woman physician told the following story: A tomcat owned by two solicitous old maids had a habit of going to the door at about 9 o'clock each night and scratching as an indication that he wanted to get out. Once outside of the house that was the last seen of him until the following day when he returned somewhat battered up and having a dejected appearance, but after sleeping quietly in an armchair or in the lap of one of the old maids throughout the day he exhibited the usual desire to get out at 9 P. M. and would spend another night of dissipation only to return the following day with the usual earmarks. Some friend advised the old maids that a veterinary surgeon could perform a simple operation on the tomcat and forever afterwards he would stay at home and be content with the humdrum life of his comfortable home. Therefore, being assured by the veterinarian that he could fix the tomcat so that night life would have no attractions for his feline majesty, the operation was performed, and after a few days' confinement in the cat hospital Tom was returned to his old maid owners. However, at 9 P. M. on the first night following his return from the hospital, Tom scratched at the door, was let out as usual, and just as usual failed to return until the following day when he was found to be as battered up as ever. In great alarm the old maids called the veterinarian and told him that Tom had not been cured. The veterinarian replied that they would have no further trouble, but upon being asked why Tom should have gone out the first night after the operation the veterinarian replied, "Oh, he was just out cancelling his dates and now he will stay at home."

It has been said that every great man has a hobby that is entirely foreign to his vocation. It also has been said that every man should have a hobby. We know a very busy surgeon who spends his odd moments in making lawn and porch furniture of artistic design for himself and his friends. We know another surgeon who is an artist of sufficient talent to justify the appearance of his paintings in public exhibitions. We know another physician who is an expert in color photography and moving pictures. Still another physician acquaintance spends his odd moments in making the finest kind of rods, together with flies and artificial baits used in his favorite recreation. Then we might mention several other instances where a physician has a hobby that requires time and no mean talent with the effort to produce practical results, yet offering a diversion from the exactions of a busy practice. All of this is well enough as long as the hobby does not get the best of the man, but we know several instances where a hobby has been given preference to real serious work, and then the hobby is harmful. For instance, we know of one physician who made a hobby of fine race horses. At first he devoted a limited amount of his time to the hobby, but finally he became so interested in his hobby that he neglected his practice and very naturally he began to lose his patronage. Race horses seldom are profitable and the physician eventually found himself without race horses and without medical practice. He now is trying to eke out an existence by filling a position as traveling salesman. We know of a number of instances that are analagous, so we offer the suggestion to the physician who has a hobby that he studiously guard against the possibility of having the hobby rule him.

The National Grange is attempting to solve the question of how to give medical service to rural communities and is asking for the co-operation of the American Medical Association. We believe that the solution of this question, as mentioned before in the columns of this journal, lies in an effort on the part of people residing in rural communities to pay a physician decent remuneration for remaining in their community. Too often the physician in the rural community is used in emergency only, and the people of the community chase off to a nearby city for much attention that could be given equally as well at home. We are not unmindful of an argument we often have made that a physician who renders good service will have no difficulty in obtaining patronage, but we realize that the general tendency on the part of people in the rural communities is to overlook the man right at home in the mistaken belief that something better may be obtained farther away, and thus much time is lost to the rural physician in gaining that prestige and especially the income that is his due. We are not in favor of offering salaries for rural service, though it could be arranged whereby the income from practice could be increased through an honorarium as local health officer, and the community as a whole could guarantee that the phy-

sician in the community would have a reasonable income from practice. In reality the practice of medicine is a business, insofar as it offers an avenue for the support of the physician and his family, and no physician willingly will begin or continue practice in a rural community when he cannot make a decent living there for himself and family, and that is the problem that must be solved. Find some way to make rural practice more remunerative and there will be no trouble about getting physicians to fill places in rural communities.

IN our June number we commented on the attitude of the *New York State Journal of Medicine* in lowering its standards for the acceptance of advertising and thus prostituting its pages for commercial gain. Instead of setting an excellent example by issuing a medical journal of high standard, both in its reading and advertising pages, the *New York State Journal of Medicine* places itself in the position of being condemned by all right thinking physicians for the adoption of a policy that is inexcusable. That our analysis of the matter is correct is evidenced by what we see in the June number of the aforesaid periodical which, on page 678, has the following to say on the advertising proposition: "The increased receipts from the advertising pages are proof to the editors that physicians read THE JOURNAL and profit by what they read." In view of the fact that that very issue contains ten advertisements, or a total of four pages of advertising, which practically none of the other state medical journals will accept, it is easy to understand the reason for the increased receipts. This is a tacit admission that the *New York State Journal of Medicine* is out for the money, and that being the case why not get the advertising for Lydia Pinkham's Vegetable Compound, Munyon's Home Remedies, and a host of other patent medicine advertisements which no doubt could be secured and at a profitable return. The income perhaps could be still further increased by adding the advertisements for Spratt's Dog Remedies. In the meantime what do the medical men of the State of New York who have regard for professional ethics and consistency in all professional conduct think of the policy now being pursued by their official journal? No valid excuse can be given by the editors and publishers of the *New York State Journal of Medicine* for refusing to be guided by the reasonable standards adopted and followed by the *Journal of the American Medical Association* and practically all of the official state medical journals. The medical men of the state of New York should bow their heads in shame, for their offical journal certainly is worshipping at the feet of the golden calf.

EVERY physician is familiar with the type of patient who must be seen out of hours and given an unusual amount of attention in order to be satisfied. Usually such patients are not desirable and for the reason that they abuse the privilege granted them, to say nothing of being unappreciative to the extent of either delaying payment for the services rendered or perhaps neglecting or refusing to pay at all. Then there is another type of patient who never is quite satisfied unless discommoding some one. Sometimes the tables can be turned, as evidenced by the following actual instance: A well-to-do merchant, known to be very exacting of all those who render him service, called a busy specialist and requested a Sunday appointment and specified 11 A. M. as the exact hour when he must receive attention. The physician answered the request by saying that he had no Sunday hours, as he saved that day for church and such recreation as he felt was needed after a week of strenuous work. The merchant answered by saying that he could not leave his business on a week day and if the specialist could not give him attention on Sunday as desired it would be necessary to consult someone else. Not wishing to offend such a prominent and desirable patient the specialist finally agreed to break his usual rule and make the examination at the appointed hour on Sunday. It so happened that the very week that the appointment was made there was a golf tournament going on at the country club, and late one afternoon during the tournament the specialist, after his office hours were over, drove to the country club to watch the wind-up of the tournament. Imagine his surprise when the first man he ran into was the prominent merchant who had said that he could not leave his place of business during week days. Upon inquiry it was learned that the merchant had been at the country club throughout the entire day and had followed the players from early morning. Upon being twitted with the fact that golf seemed to be more important than either business or an appointment with his physician, the merchant shamefacedly admitted that perhaps he had been a little severe in asking for service out of usual hours, and promised to be at the doctor's office the next day whenever an appointment could be made. He not only found it convenient to leave his business and come to the specialist's office during established hours but he never after asked unusual favors. We are inclined to believe that any patient worth having will respect the office hours and convenience of his physician or specialist, and that nothing really is gained by showing unusual favors to a class of patients who if given an inch will take a mile.

The following Indiana physicians registered at the Minneapolis session of the American Medical Association:

MONDAY, JUNE 11

Charles J. Adams, Kokomo; A. E. Bulson, Jr., Fort Wayne; J. V. Cassady, South Bend; Wm.

F. Clevenger, Indianapolis; R. E. Cole, Muncie; Charles N. Coombs, Terre Haute; F. W. Cregor, Indianapolis; Barton W. Egan, Logansport; Harry Elliott, Brazil; Wm. H. Garner, New Albany; Alfred Sabato Giordano, South Bend; Mr. Thomas A. Hendricks, Indianapolis; John W. Hilbert, South Bend; C. Fred Inlow, Shelbyville; Harry Leo Kahan, Gary; Marie Barbara Kast, Indianapolis; Frank H. Kelly, Argos; Wm. H. Kennedy, Indianapolis; John J. Kerrigan, Michigan City; Robert Lee Kerrigan, Michigan City; Wm. F. King, Indianapolis; Russell W. Kretsch, Hammond; Hugh D. Kuhn, Hammond; Cavins R. Marshall, Indianapolis; S. E. Mentzer, Monroeville; Arvine E. Mozingo, Indianapolis; David Ross, Indianapolis; E. M. Shanklin, Hammond, Lorin W. Smith, Wabash; T. M. Smith, Marysville; Harmon L. Stanton, Evansville; Albert E. Sterne, Indianapolis; Harold M. Trusler, Indianapolis; Heilman C. Wadsworth, Washington; J. H. Warvel, Indianapolis; M. M. Wells, Fairland; John A. White, Indianapolis; Fred B. Wishard, Anderson.

Tuesday, June 12

J. B. Berteling, South Bend; R. M. Bolman; Fort Wayne; Don F. Cameron, Fort Wayne; L. H. Eshleman, Marion; L. F. Fisher, South Bend; Austin Funk, Jeffersonville,; J. H. P. Gauss, Indianapolis; Alice Gracy Giordano, South Bend; Alois B. Graham, Indianapolis; Wallace S. Grayston, Huntington; Frank S. Kitson, North Manchester; Ernest L. Mattox, Terre Haute; S. E. Mentzer, Monroeville; Robert A. Milliken, Indianapolis; J. H. Reed, Logansport; William C. Reed, Bloomington; B. H. Rhamy, Fort Wayne; J. W. Rickitts, Indianapolis; J. O. Ritchey, Indianapolis; Floyd T. Romberger, LaFayette; Will Shimer, Indianapolis; Walter M. Stout, New Castle; E. M. Van Buskirk, Fort Wayne; W. M. Veazey, Avilla; G. G. Wimmer, Huntington; Shelby W. Wishart, Evansville.

Wednesday, June 13

H. R. Allen, Indianapolis; H. F. Beckman, Indianapolis, John W. Carmack, Indianapolis; Chas. E. Caylor, Bluffton; J. A. Craig, Greenwood; Frank S. Crockett, LaFayette; D. O. Kearby, Indianapolis; Edward L. Lingeman, Indianapolis; William Maddox McClarin, Indianapolis; Maurice C. McKain, Columbus; Adah McMahan, LaFayette; Ernest Rupel, Indianapolis; R. L. Sensenich, South Bend; Wm. S. Tomlin, Indianapolis; Harry E. Voyles, New Albany; Luther Williams, Indianapolis; LeRoy A. Wilson, Michigan City; Noah Zehr, Fort Wayne.

DEATHS

IN MEMORIAM

Frank A. Morrison, M.D.

Frank A. Morrison, M.D., prominent eye surgeon of Indianapolis, died at the home of his daughter, Mrs. Albert Rabb, June 7. Death was due to a cerebral hemorrhage.

Dr. Morrison was born in Indianapolis, January 31, 1860, the son of James Morrison and Henrietta Athon Morrison. His mother was a well known writer and was the author of numerous essays and poems. Dr. Morrison obtained his medical education at the Indiana Medical College, Indianapolis, from which he graduated in 1880. For a while Dr. Morrison practiced general medicine, then he went to New York and Philadelphia where he studied diseases and surgery of the eye, ear, nose and throat. He returned to Indianapolis where he practiced this specialty for a few years but later devoted all of his time to surgery and treatment of the eye. He obtained recognition throughout the Middle West for his knowledge and skill as an eye surgeon and was noted for his work among the poor.

Dr. Morrison served on the staff of the Indiana University School of Medicine for forty-eight years, and for thirty-three years on the instructional staff of the Indiana Dental College. He was physician for the Indiana State School for the Blind for forty years, and also served a term as a member and as president of the Indianapolis School Board, and the City Board of Health. Dr. Morrison had been professor of ophthalmology at the Indiana University School of Medicine since its organization. Recently the Department of Opthalmology of the School was given an endowment of $25,000 by William H. Coleman, and Dr. Morrison was made trustee of the fund.

Dr. Morrison was a member of the Indianapolis Medical Society, the Indiana State Medical Association, a Fellow of the American Medical Association, a member of the American Academy of Ophthalmology and Otolaryngology, and a Fellow of the American College of Surgeons.

Samuel E. Smith, M. D.

S. E. Smith, M.D., of Indianapolis, died May 29, following an illness of three months. Dr. Smith was provost of the medical group in Indianapolis controlled by the Indiana University.

Dr. Smith was born August 21, 1861, in Gosport, Indiana. He obtained a B.S. degree from Indiana University in 1882, and an M.D. degree from the University of Louisville School of Medicine in 1884. Later he received the degree of Master of Science from Indiana University. In 1891 Dr. Smith went to Richmond as medical superintendent of the Eastern Indiana Hospital for the Insane where he served until 1923, making the longest continuous record as head of a public institution in the history of the state. He planned and supervised construction of the Southeastern Hospital for Insane at Madison, and presided over the commission on the location of the State Penal farm in 1913. He resigned his position with the Eastern Indiana Hospital for Insane in 1923 to accept the Indiana University post as pro-

vost, having charge of the general administration of the state school branches in Indianapolis. How well his work was done with this institution may be shown by Dr. Charles P. Emerson's words, "Dr. Smith's death is an irreparable loss. I consider him one of the most efficient hospital administrators with whom I ever have been associated. In his ability to plan work and carry through his plans he was without a peer."

Dr. Smith was a member of the Wayne County Medical Society, the Indianapolis Medical Society, the Indiana State Medical Association, the American Psychiatric Association and a Fellow of the American Medical Association.

ALBERT M. COLE, M.D.

Albert M. Cole, M.D., of Indianapolis, prominent physician and pioneer in the development of roentgenology, died June 4, aged 58 years. He had been ill for four weeks.

Dr. Cole made notable contributions to the development of the x-ray. He graduated from the Indiana Medical College, School of Medicine of Purdue University, Indianapolis, in 1894, and from the University of Pennsylvania School of Medicine, Philadelphia, in 1896.

Dr. Cole was a member of the American Roentgen Ray Society, the American College of Radiology, the Indianapolis Medical Society, the Indiana State Medical Association, and a Fellow of the American Medical Association.

ROBERT C. LIGHT, M.D., of Indianapolis, died May 18, aged seveny-one years.

ROSS M. REAGAN, M.D., of Monon, died May 19, aged fifty-eight years. Dr. Reagan graduated from the Medical College of Indiana, Indianapolis, in 1896.

WILLIAM H. HAIFLEY, M. D., of Muncie, died June 5, aged sixty-four years. He was not in active practice at the time of his death. He graduated from the Eclectic Medical College of Cincinnati in 1891.

IRWIN A. DETCHON, M.D., of Crawfordsville, died May 28, aged 78 years. Dr. Detchon had been ill for several months. He was a graduate of the University of Pennsylvania School of Medicine, Philadelphia, in 1876.

W. H. MCCLURG, M.D., of Kokomo, died June 10, following an illness of six years duration. Dr. McClurg was sixty-eight years of age. He had practiced medicine in Kokomo for forty-one years. Dr. McClurg was a member of the Howard County Medical Society and was a graduate of the Medical College of Indiana, Indianapolis, in 1887.

C. L. RITTER, M.D., of Gosport, died June 3, aged seventy-three years. He was a member of the Owen County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from the Eclectic Medical College of Cincinnati, Ohio, in 1879, and from the Medical College of Indiana, Indianapolis, in 1883.

GEORGE T. JOHNSON, M.D., of Terre Haute, was killed in an interurban collision, June 1. Dr. Johnson was a prominent surgeon of Terre Haute and was only forty-two years of age. He had served as secretary of the City Board of Health of Terre Haute. He was a member of the Vigo County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from Rush Medical College, Chicago, in 1908.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

DR. C. P. CLARK, of Indianapolis, was the principal speaker at a meeting of the Tri-County Medical Society held at North Vernon, May 16.

DR. P. C. TRAVER has announced the removal of his office to 830 Sherland Building, South Bend.

DR. C. W. RUTHERFORD, of Indianapolis, has moved to Iowa City, Iowa, where he will work with the University Hospitals.

DR. AND MRS. R. C. BEELER, of Indianapolis, sailed from New York on June 6 for Stockholm, Sweden. They will be gone several weeks.

DR. H. S. LEONARD has been appointed to the board of public health of Indianapolis to succeed Dr. W. E. Mendenhall whose term expired.

DR. GEORGE F. KEIPER, a member of the Tippecanoe County Medical Society, has moved to Los Angeles, California, where he will practice medicine.

AN effort is being made to establish a hospital for negroes in Evansville. Because of the large negro population of that city a hospital of this type is badly needed.

DR. AND MRS. F. G. JACKSON, and daughter, Miss Lola Jackson, of Muncie, have recently returned from an extended visit to Egypt, Europe, Turkey and the Holy Land.

THE last monthly meeting of the Hamilton County Medical Society before the summer vacation was held at Forest Park, Noblesville, June

12. Dr. A. M. Mendenhall, of Indianapolis, presented a paper.

Dr. Shelby Wishart, of Evansville, attended the American Medical Association meeting at Minneapolis, where he discussed Dr. Maxwell's and Dr. Bradley's paper on "Primary Tumors of the Heart."

Drs. J. F. Wynn and A. E. Allenbaugh, of Evansville, attended clinics given by the University of Cincinnati Medical School the week of June 10 to 17.

Dr. R. J. Masters, 601 Hume-Mansur Building, Indianapolis, has been appointed secretary-treasurer of the Indiana Academy of Ophthalmology and Otolaryngology to succeed Dr. C. W. Rutherford, who is removing from the state.

Dr. B. W. Rhamy, of Fort Wayne, was elected a member of the Board of Censors of the American Society of Clinical Pathologists at the meeting of that society held in Minneapolis, June 8 to 12.

The June meeting of the Madison County Medical Society was held in Elwood, June 20. Guest privileges at the Elwood Country Club were available for those desiring to play golf. A picnic supper was served at Dr. Hoppenwrath's home.

At the May 24th meeting of the Fourth District Medical Society, Greensburg was selected as the place for the 1929 meeting of the society. Officers were elected as follows: president, Dr. E. T. Riley, of Greensburg; secretary, Dr. P. C. Bentle, of Greensburg.

The last regular meeting of the Henry County Medical Society, before the summer vacation period, was held June 12, at the residence of Dr. W. C. Van Nuys, Newcastle. About twenty-five physicians attended the meeting. The next meeting of the society will be held in September.

The Fourth District Medical Society held its meeting at Dillsboro, May 24th. Addresses were presented by the president of the society, Dr. J. M. Jackson, of Aurora; Dr. C. E. Gillespie, of Seymour; Harry R. McMullen, attorney, Aurora; Dr. H. P. Long, Dillsboro; Dr. Edwin Kime, Indianapolis; and Dr. G. F. Smith, Lawrenceburg.

Through the will of the late Dr. Frank Morrison the Indiana University School of Medicine Library will receive his entire ophthalmological library which will be maintained and added to as a memorial to him. The University Library also has received one hundred and fifty volumes from the estate of Dr. A. M. Cole.

The St. Mary's Hospital staff of Evansville obtained Dr. Charles P. Emerson, of Indianapolis, to conduct a medical clinic on May 29. He presented a number of interesting cases. A banquet preceded the medical clinic. A large number of local physicians and physicians from adjoining counties were in attendance.

At the May 18th meeting of the Muncie Academy of Medicine held at the Delaware Hotel, Dr. Robert M. Moore, of Indianapolis; Dr. J. O. Ritchey, of Indianapolis; Dr. R. L. Lochry, of Indianapolis; Dr. R. E. Cole, of Muncie; and Dr. W. C. Moore, of Muncie, presented a symposium on "Goitre."

At a recent meeting of the Fort Wayne Medical Society Dr. M. B. Catlett was elected president, Dr. D. F. Cameron, vice-president; Dr. E. S. Parmenter, secretary, and Dr. Homer C. Glock, treasurer. Dr. D. D. Johnston and Dr. B. W. Rhamy have been named delegates to the state convention.

Dr. William Alexander Young died May 29, at Akkra, Africa, of yellow fever. Dr. Young was a member of the scientific party sent to Africa by the Rockefeller Institute for Medical Research to conduct research on yellow fever. He is the third physician to give up his life in this work within the last few months, the others being Dr. Adrian J. Stokes, of England, and Dr. Hideyo Noguchi, of New York.

Dr. Edwin N. Kime, of Indianapolis, recently attended the meeting of the Massachusetts State Medical Association where he presented a paper before the Section on Radiology and Physical Therapeutics. His subject was "Electro-surgery." Dr. Kime also recently presented a paper before the Fourth District Medical Society at Dillsboro, Indiana, his subject being "Present Status of Physical Therapy."

At the May 24th meeting of the Indianapolis Medical Society, the past presidents of the society were presented certificates. They were Drs. William N. Wishard, Hugo O. Pantzer, Samuel E. Earp, Harry E. Gabe, Charles E. Ferguson, David Ross, Alois B. Graham, Thomas B. Noble, Norman E. Jobes, Charles F. Neu, James H. Taylor, Amos L. Wilson, John W. Sluss, Lafayette Page, John F. Barnhill, Joseph R. Eastman, Alfred S. Jaeger, Homer G. Hamer.

Earl W. Gayer, M.D., formerly of Indianapolis, and now in practice at Rochester, N. H., still maintains his membership in the Indianapolis Medical Society. Dr. Gayer writes that New Hampshire is a wonderful state in which to enjoy a vacation and that he will be more than pleased to see any of his Indiana friends if they

come to Rochester. He is specializing in genito-urinary and skin diseases.

THE Inter-State Post Graduate Medical Association of North America will hold a meeting at Atlanta, Georgia, October 15 to 19, 1928. Dr. George W. Crile, chairman of the program committee, has arranged an attractive program, with eighty-two clinicians and teachers from all sections of the United States and Canada occupying places on the program. All medical men in good standing are privileged to register, and all are invited to attend. Dr. William B. Peck, of Freeport, Illinois, is managing-director of the Association.

DR. JAMES WILSON, of Wabash, was elected president of the Eleventh Indiana Councilor District Medical Society to succeed Dr. J. H. Reed, of Logansport, at the thirty-ninth semi-annual meeting of the organization held May 12. Dr. O. G. Brubaker, of North Manchester, was re-elected secretary-treasurer. The presidents of the seven county societies in the district are vice-presidents of the Eleventh District Society. Marion was selected for the meeting place to be held in October.

THE regular monthly clinic program of the Welborn Hospital Clinic was held June 20. The morning session consisted of surgical clinics conducted by Drs. J. Y. Welborn and W. R. Davidson. A medical clinic was held in the evening. Dr. W. W. Eichelberger, neuropsychiatrist of the Jacksonville State Hospital, Jacksonville, Illinois, presented a paper on "The Malarial Treatment of Neuro-syphilis." This was followed by a symposium on "Infections of the Hand," which was accompanied by a moving picture "Diagnosis and Treatment of Infections of the Hand."

THE United States Civil Service Commission announces open competitive examination for Associate Physiologist, applications for which position must be on file with the Civil Service Commission at Washngton, D. C., not later than August 8. Examinations are to fill vacancies in the Hygienic Laboratory, Public Health Service, Washington, D.C., at a salary of $3,600 per year. Duties are to carry on research in general physiology involving studies on unicellular organisms and tissue culture. Full information may be obtained from the U. S. Civil Service Commission at Washington, D.C.

THE Indiana Tuberculosis Association offers short courses in tuberculosis to the physicians of Indiana. To make it possible for physicians to attend these courses without great loss of time, several sanatoria of the state will be used as teaching centers. Anyone wishing to attend may select any place preferred. Only two days will be devoted to the work. Courses will be held at the following institutions, on the dates indicated: Irene Byron Sanatorium, Fort Wayne, August 23 and 24; Sunnyside Sanatorium, Oaklandon, September 11 and 12; Healthwin Sanatorium, South Bend, August 16 and 17; Lake County Tuberculosis Sanatorium, Crown Point, August 29 and 30; Indiana State Sanatorium, Rockville, September 13 and 14; Boehne Tuberculosis Hospital, Evansville, September 27 and 28. There will be no fees attached to the course which is being presented as an aid to the medical profession. Full information may be obtained by writing to the Indiana Tuberculosis Association, 1220 Meyer-Kiser Bank Building, Indianapolis.

In addition to the articles already enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

H. K. Mulford Co.:
- Diphtheria Toxoid-Mulford.

Parke, Davis & Co.:
- Glaseptic Ampoules Solution Glucose, 50 per cent, 20 cc.
- Glaseptic Ampoules Solution Glucose, 50 per cent, 50 cc.
- Stearodine
 - Stearodine Tablets.

Pasteur Institute of St. Louis:
- Antirabic Virus (Semple).

G. D. Searle & Co.:
- Bismuth Sodium Tartrate-Searle.
 - Ampoules Bismuth Sodium Tartrate-Searle, 2 cc.

Swan-Myers Co.:
- Biennial Sage Concentrated Pollen Extract-Swan-Myers.
- Pollen Extracts-Swan-Myers 2000 unit packages.

Change of Agency: Viking Palatable Cod Liver Oil, formerly distributed by Sigurd E. Roll, Chicago, is now distributed by Viking Health Products Co., Chicago. The Council has continued the acceptance of Viking Palatable Cod Liver Oil under the new distributor.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

May 21, 1928

Meeting called to order at 4:45 P. M.

Present: Wm. N. Wishard, M.D., chairman; Murray N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held May 14, read, corrected and approved.

The release, "Some Facts About Yeast" was read, corrected and approved for publication, May 26.

The following letter was received from the executive secretary of the Indiana Tuberculosis Association:

"I am pleased to advise that at the last meeting

of our Board of Directors, held on May 11, the following resolution was adopted:

"RESOLVED, that the Indiana Tuberculosis Association express its appreciation to the Indiana State Medical Association for the splendid co-operation and support given to the Early Diagnosis Campaign, conducted in this state, and for its contribution in making the program successful.

"May I add my personal expression of sincere thanks for the splendid help we have had?"

Upon the request of an editor of one of the state's leading newspapers, the Bureau received from the Bureau of Investigation of the American Medical Association, a report upon "Radium Ore Revigator" discussing radium jugs that are now being sold to the public and said to be capitalizing the public's ignorance on radium and radio activity. The Bureau expressed its appreciation for the work that has been done by the Bureau in this particular case and in general. This information was forwarded to the editor of the newspaper requesting it.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole May 28, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

June 4, 1928.

Meeting called to order at 4:45 P. M.

Present: Wm. N. Wishard, M.D., chairman; J. A. MacDonald, M.D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held May 21, read, corrected and approved.

The release, "Vacations and Typhoid Fever," was read, corrected and approved for publication Saturday, June 9.

The following bills were approved for payment:

Central Press Clipping Service	$5.00
The Kautz Stationery Co.	1.50

Report of the meeting of the Third District Medical Society May 10 received. The Bureau supplied a speaker for the meeting who talked upon "Some Clinical Manifestations of Acute Rheumatic Pericarditis."

The report of "The Cattaraugus County Medical Society and the Milbank Health Demonstration" received by the Bureau of Publicity. The Bureau specially noted the eight fundamental principles that were outlined in the report as those principles which govern the relation of medical and lay organizations in the conduct of public health demonstration. These fundamental principles are said to have been approved recently by the House of Delegates of the New York State Medical Society. They are as follows:

PUBLIC HEALTH PLATFORM

"Eight fundamental principles, formulated by conferences arranged by the State Medical Society, and submitted to the House of Delegates of the New York State Medical Society with the recommendation that they be formally approved as a tentative code for all relations between the medical profession and lay health organizations.

1. The essential part of public health work being preventive medicine, there should be no failure on the part of official and unofficial health and welfare organizations to recognize the importance of the local practicing physician.

2. All those associated in the conduct of public health activities must recognize fully that preventive medicine is the doctor's rightful field and that laymen must at all times look to the medical man for guidance and leadership therein.

3. Public health work within a county involves three participating factors—lay organizations, official governmental agencies, and the members of the county medical profession.

4. The evolution of a county health program should be the evolution of medical forces within the county. It is the duty of the local physicians to assume leadership in the organization and management of a county health department.

5. The function of lay organizations and employees of the county health organizations, acting under the leadership of the practicing physicians of the county, includes assistance in educational work, in helping those who are unable to carry out the doctor's advice, and in providing means whereby the public health program may be carried out.

6. Lay organizations are needed in the county. Their co-operation is to be welcomed by the physicians. They are needed for the great educational work they can do, for their influence on public opinion, legislation and laws, and in many other ways. But preventive medicine must be controlled and guided by the medical men of the county.

7. As the function of the county health officer is not to exercise the function of the physicians of the county but to explain the facilities and stimulate the use of these facilities by the citizens, therefore, before any innovations are put into effect by a demonstration or other agency, they should first be thoroughly studied and discussed by the medical society and the professional membership of the county board of health.

8. All local publicity should be of fact and simply to inform the people of the county of public health work which is being done, why it is being done, and why it should be done."

The Bureau was to ask the Cattaraugus County Medical Society to send a copy of this report to the editor of THE JOURNAL of the Indiana State Medical Association.

The following letter was received:

"DEUTSCHE ZENTRALE
Fur
GESUNDHEITSDIENST DER LEBENSVERSICHERUNG E. V.

Wissenschaftliche Leitung
Dr. Med. O. Neustatter

Berlin-Zehlendorf-West
Seestr. 47
Tel. G4 Zehlendorf 4966

The 22nd May, 1928

To the Secretary of the
Indiana State Medical Association,
Indianapolis, Indiana,
U. S. A.

Dear Sir:

I should appreciate it very much if I could get your bulletins on the importance of common colds, measles and investigations in other lines that you have been occupied in.

Very truly yours,
(Signed) OTTO NEUSTATTER."

The secretary was instructed to answer this letter giving the writer all information possible.

Arrangements have been completed with the Director of Radio of WFBM, Indianapolis Power and Light Company, Indianapolis, Indiana, to broadcast a ten-minute health talk at 6:50 P. M. Saturday night of each week. These weekly broadcasts were to begin Saturday, June 9.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole June 11, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

WOMAN'S AUXILIARY

The 1928 meeting of the Woman's Auxiliary to the American Medical Association in Minneapolis was highly interesting to all in attendance; work and play were combined during the five days of the session, giving a pleasant memory to hundreds of women.

As is the custom, the retiring and incoming presidents of the American Medical Association addressed the ladies, lauding them for their conservatism and ideals. Dr. Jabez N. Jackson warned, "Beware of entangling alliances," and President William S. Thayer said, "Women can do things that men cannot."

The Woman's Auxiliary now numbers about ten thousand paid-up members in thirty states, besides seven states in process of organization. The potential membership of this Woman's Auxiliary with its wonderful opportunity for service is breath-taking.

Mrs. John O. McReynolds, of Dallas, Texas, national president, was luncheon-hostess on Tuesday at the Women's Club building; present were her officers and delegates and the wives of the Trustees of the American Medical Association. The guests were entertained with a musicale given by Mrs. Ralph S. Chappell, soprano, and Mrs. F. W. Cregor, pianiste, of Indianapolis. Mrs. McReynolds announced that the Missouri Auxiliaries had won her one hundred dollar prize by securing more than one thousand subscriptions for *Hygeia*. She also announced that a friend of hers had offered the choice of an automobile or a trip to Europe, to be awarded to the first state sending in one thousand subscriptions for *Hygeia* and that state in turn to present the prize to the individual securing the largest number of the aforementioned subscriptions in ninety days. This contest is to begin the first of September.

Mrs. McReynolds addressed the House of Delegates of the American Medical Association, reviewing the work of the Auxiliary for the year; she was received enthusiastically. Any apprehension for the success of the Woman's Auxiliary to the medical profession has been dispelled by the safeguards thrown around the organization by the Advisory Council for the national body, as well as the control of activities by state associations and county societies which may be depended upon to keep it "out of entangling alliances," mentioned by Dr. Jackson, and enable it to do things that "only women can do" as stressed by President Thayer.

Copies of Mrs. Cregor's paper, "Medical Legislation," will be sent to all state presidents, that the wives of members of the American Medical Association gradually may gain knowledge of legislation in which their physician-husbands are involved or interested. Mrs. Cregor regrets that not many Indiana women attended the meetings in Minneapolis; perhaps Portland, Oregon, in 1929, will find more registered.

The new president of the Woman's Auxiliary to the American Medical Association, Mrs. Allen Bunce, of Atlanta, Georgia, will be an inspiration and a leader, as was Mrs. McReynolds who ended her presidential duties at Minneapolis but not her active interest in the Woman's Auxiliary.

Respectfully,
MRS. FRANK W. CREGOR.

WELLS COUNTY MEDICAL SOCIETY FIFTIETH ANNIVERSARY

The Wells County Medical Society celebrated the fiftieth anniversary at a dinner meeting held at the New City Hall, Bluffton, on Tuesday evening, June 5, 1928.

There were about thirty physicians present, several members of the adjoining counties of Huntington and Adams being present as guests of the Wells County Medical Society.

The first speaker on the program was Dr. George S. Bond, Professor of Medicine, Indiana University School of Medicine, who gave a very interesting and instructive talk on "Angina Pectoris." A general discussion followed Dr. Bond's paper.

Dr. I. N. Hatfield, Bluffton, was the next speaker and he presented a brief resume of the History of the Wells County Medical Society.

Respectfully,
MAX M. GITLIN, M.D.
Secretary.

TENTH DISTRICT MEDICAL SOCIETY

The Tenth District Medical meeting was held at the country home of George Ade, at Brook, Indiana, on June 7, 1928.

There was a good attendance. The day's entertainment consisted of golf in the morning, luncheon at noon at the clubhouse, which was followed by a scientific program in the afternoon. A paper was presented by Dr. John Ellis, of Chicago, on "Fractures of the Bones of the Foot," this being followed by another paper by Dr. Donald P. Abbott of Rush Medical School of Chicago on "Diseases of the Colon."

Dr. Blount, of Valparaiso, and Dr. H. G. Cole, of Hammond, were elected president and secretary respectively for the ensuing year.

It was decided that due to the state meeting in Gary this fall that the next meeting of the Tenth District Medical Society would be held in Gary next spring.

Very truly yours,
H. G. COLE, M.D.,
Secretary.

FOUNTAIN-WARREN COUNTY MEDICAL SOCIETY

The Fountain-Warren County Medical Society held a meeting "on the Banks of the Wabash" at Covington, Indiana, as guests of the Covington physicians, June 11, for a fish dinner and to hear Dr. Louis H. Segar, of Indianapolis, talk on "Acute Colds and Resulting Sinus Complications in Young Children."

There was a large attendance and a very enjoyable evening was spent by the members and guests.

Respectfully,
A. L. SPINNING, M.D.,
Secretary.

VANDERBURGH COUNTY MEDICAL SOCIETY

The June meeting of the Vanderburgh County Medical Society was held at the Boehne Tuberculosis Hospital, Tuesday, June 12, at 8:00 p. m.

Dr. Henry Stempa read a paper on "The Value of the Microscopical Examination of Sputum from Tuberculosis and Nontuberculosis Patients." Dr. Stempa reported that he is attempting to prognosticate as to the extent of the tuberculous involvment of the lungs, from the character of cells found in the sputum. He also believes it is possible to diagnose, in some cases, the presence of pulmonary tuberculosis from the type of cells found, in spite of a failure to find tubercle bacilli in the sputum.

Dr. G. E. Mills, superintendent of the Boehne Tuberculosis Hospital, was ill and was unable to present his paper. Dr. G. C. Johnson, president of the society, therefore read Dr. Mills' paper on "The Tuberculosis Sanitarium" before the society.

Respectfully,
KEITH T. MEYER, M.D.,
Secretary.

TIPPECANOE COUNTY MEDICAL SOCIETY

June 15, 1928

The Tippecanoe County Medical Society met at the LaFayette Country Club for the June and last meeting until September. Dinner was served at 6:30 P. M. A small but interested group of members were present.

Physicians' wives were guests of the society.

President Laws presided at the meeting. The minutes of the April meeting were read and approved. The application of Dr. C. D. Thomas was read the second time and voted in unanimously. No committee reports were given, except that several things are being considered, and will be reported later. Motion was made and carried that the Legal Committee, composed of Drs. J. W. Shafer, A. J. Bauer and D. H. McKinney, should investigate certain irregularities in the practice of healing in our city, and report at the September meeting. Also, they will investigate the advisability of incorporating our society and report at the September meeting.

The following bills were ordered by motion:

Perry the Printer, cards	$ 7.50
Dr. C. P. Emerson, traveling expenses, May 17, 1928	7.14
Brown, eight extra plates by members	8.00
Total	$22.64

Dr. C. B. Kern gave an interesting address on the subject, "Why We Behave Like Human Beings."

Motion to adjourn was carried.

J. C. BURKLE, M.D.,
Secretary.

MADISON COUNTY MEDICAL SOCIETY

The Madison County Medical Society held its annual out-of-doors frolic and picnic on June 20, and the regular date on Tuesday was changed to Wednesday to permit the enjoyment of a full afternoon, as most of the members take that afternoon for a holiday.

At the invitation of the Elwood members and Dr. and Mrs. Hoppenwrath, the meeting was held at their summer home a mile and a half south of Elwood and opposite the Country Club. The Committee on Arrangements, Drs. Hoppenwrath, Lauderman and Fitzpatrick, are to be congratulated on the great success of the day. In the afternoon the privileges of the Country Club gave the golfers a chance to try their skill on a very sporty course. The wives of the members were entertained at bridge and at 6 o'clock well-filled baskets were brought forth and the good things that were put out to eat were worthy of the good wives and the occasion. When the supper had time to settle a bit, Eddie Lands' orchestra appeared and rendered selection for dancing until 1 A. M. Besides this a regular six-act vaudeville performance had been arranged, and the local talent that had been secured to supply this entertainment was better than the average seen on the stage. It consisted of a quartette composed of Elmo Gustin, Charles Babbitt, Arthur Bell and Howard Harnden, accompanied by Mrs. Babbitt. Readings by Mrs. F. A. Schoenberger and O. W. Coxen. Demonstrations in magic by M. Francois, and impersonations by Fitch Cooper.

Besides a number of friends of the physicians, and several doctors and their wives from neighboring counties, the following members and their wives were in attendance: Conrad, Wishard, Knight, Metcalf, Tracy, Kopp, Guthrie, Quickel and Austin of Anderson, Irwin of Summitville, Hunt of Pendleton, Hall of Alexandria, Hanna of Noblesville, and the following from Elwood: G. V. Newcomer, Cullipher, Lauderman, Fitzpatrick, King, Harrold, Ploughe, Mendenhall, Owen, Frank Newcomer and M. W. and W. H. Hoppenwrath.

Respectfully

M. A. AUSTIN,
Secretary.

BOONE COUNTY REVIVAL MEETING AT LEBANON

Colleges have their pep meetings, political parties their rallies, families their reunions and fraternal orders their get-to-gethers, but no pep meeting, rally, or reunion ever excelled in spirit the meeting held by more than sixty physicians of the Ninth District Medical Society at the Ulen Country Club at Lebanon Tuesday evening, June 26.

For several years the Boone County Medical Society has suffered from a severe case of inertia, lethargy, lack of interest, inaction or what-have-you. In order to diagnose the case and set upon a course for immediate remedy, the pep party was instituted by the officers of the Ninth District. And it was a peach. Practically every County Society in the District sent a group of representatives and Dr. George R. Daniels, president, and several other representatives of the State Association were on hand to make the party thoroughly official.

"Rumors of factions in Boone County are in the air, but I dare say that factions exist in every County Society in the state or wherever there are two or more physicians in a community. Factions will continue to exist as long as men have the courage to express their own opinions. But factions should not have a thing to do with the effective functioning of a medical organization," said Dr. Frank S. Crockett of LaFayette, Councilor for the Ninth District, who organized the meeting and acted as toastmaster.

A mighty good chicken dinner served on the large sun porch of the Ulen Country Club, one of the most complete and beautiful clubs in the state, got the party away to a comfortable start. Dr. F. S. Crockett, acting as toast-master, called on a spokesman from each of the County Societies for a series of five minute talks in which they told what was being done in their own County Society along organization lines. Without exception the talks were good, the floor being taken in turn by Dr. A. L. Spinning, secretary of the Fountain-Warren County Society; Dr. M. F. Boulden, of Clinton County; Dr. Byron Lingeman, president of the Montgomery County Society; Dr. Floyd T. Romberger, of the Tippecanoe County Society who suggested the meeting and Dr. C. R. Elfers, of the Hamilton County Society. Some spoke in a humorous mood and some along serious lines, but all in an interesting and helpful way concerning the part that their County Medical Society is playing in their various communities.

Following these talks, Dr. A. L. Marshall, chairman, and Dr. David Ross, a member of the Executive Committee, and Thomas A. Hendricks, Executive Secretary, were introduced and said a few words. In the principal talk of the evening, President Daniels pointed out the necessity of good organization in each County Medical Society, the meaning of fellowship among physicians, the need of a common understanding, and the value of concerted action by the profession. Dr. John D. Coons, president, and Dr. W. H. Williams spoke for the Boone County Medical Society. The meeting closed with a most interesting talk by Dr. Robert M. Moore, of Indianapolis, and a general scientific discussion of the subject "Drug Therapy in Heart Disease."

Among those present were: Boone County—Dr. W. H. Williams, Dr. W. W. Kitson, Dr. J. R. Ball, Dr. H. A. Beck, Dr. H. N. Coons, Dr. John D. Coons, Dr J. R. Porter, Dr. Clancy Bassett, Dr. G. M. Owsley, Dr. W. H. Spieth, Dr. R. J. Harvey, Dr. Otis C. Higgins, and Dr. H. L. Baker. Dentists—Dr. O. R. Pfaff, Dr. J. A. Pam and Dr. E. W. Ellis. Clinton County—Dr. M. F. Bouldren, Dr. W. C. Mount, Dr. I. E. Carlyle, Dr. C. A. Robison, Dr. J. E. Robison, Dr. L. L. Harding, Dr. John S. Ketcham, Dr. H. R. Royster, and Dr. F. A. Beardsley. Tippecanoe County—Dr. G. M. Wells, Dr. J. C. Burkle, Dr. F. T. Romberger, Dr. C. C. Driscol, Dr. W. F. McBride, Dr. F. S. Crockett, Dr. C. V. Davison, Dr. R. H. Bayley, Dr. D. C. McClelland, Dr. W. W. Washburn, Dr. H. E. Klepinger, Dr. M. G. Frasch, Dr. G. A. Thomas, Dr. A. W. Schreiber. Hendricks County—Dr. O. A. Scamahorn. Hamilton County—Dr. C. R. Elfers. Fountain-Warren County—Dr. A. L. Spinning, Dr. J. W. Aldridge, Dr. S. Lambright. Montgomery County—Dr. George William, Dr. George

Collett, Dr. Robert Millis, Dr. T. Z. Ball, Dr. L. H. Davis and Dr. Byron Lingeman.

Respectfully,

THOMAS A. HENDRICKS.

AMERICAN MEDICAL ASSOCIATION ABSTRACT OF PROCEEDINGS OF HOUSE OF DELEGATES AT MINNEAPOLIS SESSION

The total membership of the House of Delegates is 170. At the final session in Minneapolis 154 delegates answered to the roll call.

All constituent state medical associations were represented except those of Florida, Nevada, Alaska and Hawaii. All sections of the scientific Assembly were represented by delegates except the Sections on Pharmacology and Therapeutics; Nervous and Mental Diseases; Dermatology and Syphilology, and Preventive and Industrial Medicine and Public Health.

In the address of the Speaker, Dr. F. C. Warnshuis, it was suggested that the annual speaker's address to the House of Delegates should contain no general recommendations concerning policies of the Association but that it should deal with the affairs and procedures of the House of Delegates. The Speaker urged that careful consideration should be given, and thorough review of matters submitted should be made, by reference committees, and that there should be no generalized approval of referred reports and resolutions.

The President, Dr. Jabez N. Jackson, reviewed vital changes affecting the practice of medicine, referring especially to the development of specialization and institutional care and to the exploitation of the physician in the abuse of medical charity. He offered a recommendation to the effect that there should be an investigation and classification of medical charities, either through a special committee of the Association or through the Judicial Council.

The President-Elect, Dr. William Sydney Thayer, delivered a brief address in which he called attention to the present tendency toward over-organization of the profession. Dr. Thayer paid tribute to the work of Dr. Hideyo Noguchi, lately deceased.

OFFICIAL DELEGATES

The British Medical Association; the Canadian Medical Association; the Victorian Branch of the British Medical Association in Australia, and the Medical Society of Costa Rica were officially represented by Sir G. Lenthal Cheatle of London; Dr. J. Harvey Smith of Winnipeg; Dr. R. G. McPhee of Australia, and Dr. A. Pena Chavarria of Costa Rica, as fraternal delegates, who presented greetings from their respective societies.

ACTION ON REPORT OF COUNCIL ON SCIENTIFIC STUDY

The Reference Committee on Sections and Section Work commended the report of the Council on Scientific Assembly; recommended approval of the program of diagnostic clinics and clinical lectures which preceded the regular section programs, and approved the recommendation of the Council that all questions of a scientific nature arising in the House of Delegates or in the scientific sections should be referred to the Council on Scientific Assembly for investigation and report before being considered by the House of Delegates.

The recommendations of the Reference Committee were adopted by the House.

MEDICAL EDUCATION AND HOSPITALS

The report of the Council on Medical Education and Hospitals indicated that the Council plans to devote considerable attention for the next several years to a survey of hospitals in the United States. The Chairman of the Council, in presenting the report, indicated that the difficulties of appraisal are recognized and being considered by the Council. The report also dealt in some detail with the appraisal of clinical laboratories.

The Reference Committee called attention to the fact that the appraisal of medical institutions and agencies in so extensive and so populous a country as this is a vast undertaking and urged that the policy of the Council should be carried out with great caution and in co-operation with constituent state medical associations and state authorities.

The Reference Committee strongly endorsed the recommendation of the Chairman of the Council on Medical Education and Hospitals urging that the practice of medicine is not the proper function of corporations and that the American Medical Association should use its utmost endeavors to stop this growing abuse. The Committee endorsed the substance of a resolution offered by Dr. Southgate Leigh of Virginia to the effect,

(1) That it would be desirable that medical students should graduate and enter practice at an earlier age that at present;

(2) That the plan of covering the medical course in three years of four quarters instead of in four years of three quarters, or any other adequate plan for reducing the length of the medical course, is greatly to be desired;

(3) That the medical course is overcrowded with details and with detailed consideration of specialties and would be improved by less crowding with a course confined more nearly to the essentials, and that efforts to this end should be made.

A resolution presented by Dr. John O. Polak of the Section on Obstetrics, Gynecology and Abdominal Surgery, provided that the House of Delegates should disapprove of any reduction in the hours allotted to the teaching of obstetrics and should advocate that obstetrics as a major subject be allotted a number of hours equal to those allotted to surgery. In reporting on this resolution, the Reference Committee on Medical Education made the point that the importance of a subject or the amount of work that it constitutes for the general practitioner alone is not a proper measure of the time which should be allotted to the study of that subject. The Committee also felt that definite instructions of the kind contemplated in the resolution to councils and other bodies engaged in working out difficult problems are inadvisable and that freedom and initiative should not be hampered by rigid instruction. The importance of thorough instruction in obstetrics was recognized by the Committee, but its recommendation was that the resolution of Dr. Polak be not adopted.

The report of the Reference Committee on Medical Education was adopted by the House of Delegates.

HYGIENE AND PUBLIC HEALTH

The Reference Committee on Hygiene and Public Health recommended that the House of Delegates reaffirm its endorsement of the plans outlined at a previous session for medical relief in disaster.

With respect to a communication addressed to the House of Delegates by the National Grange concerning the alleged scarcity of physicians in the rural districts, the Reference Committee offered the following resolution, which was adopted by the House of Delegates:

Resolved, that an official reply to the Grange be formulated by the Secretary of the House of Delegates embodying the following thoughts:

1. That the House of Delegates is keenly alive to the problems involved and recognizes that, although there will always be some inadequacy of medical services in sparsely settled communities, improvement of medical services in rural districts is needed.

2. That the problem is being intensively studied by the Commission on Medical Education (already in its fourth year), the Committee on the Cost of Medical Care, the Council on Medical Education and Hospitals, and other bodies.

3. That the problem is fundamentally economic and the solution involves much more than the mere length and costs of medical education.

4. That patience and time are necessary in order to obtain data and evolve methods for solving this problem.

5. That suggestions from the National Grange and information will be welcomed by the House of Delegates and by any of the bodies specially engaged in the study of medical educational and economic problems.

The Committee recommended approval of legislation providing for co-ordination and increased efficiency of the public health activities of the federal government.

The report of the Reference Committee on Hygiene and Public Health was approved.

Legislation and Public Relations

The following resolution, introduced by Dr. C. J. Whalen of Illinois, was referred to the Reference Committee on Legislation and Public Relations:

WHERAS, It has come to our attention that students in universities and colleges are being given free medical care without regard to the ability of the individual to pay for the same, therefore be it

Resolved, That the Judicial Council be requested to investigate the matter as to the extent to which this practice prevails.

The Reference Committee recommended that this resolution be referred to the Judicial Council.

A resolution providing that the Board of Trustees of the Association take leadership in the support of suitable legislation to recognize properly the services of Dr. Jesse W. Lazear and Dr. James Carroll was, on recommendation of the Reference Committee, referred to the Board of Trustees.

The recommendation of the Reference Committee with respect to the report of the committee appointed to secure revision of undesirable regulations under the Volstead Act was to the effect that this committee be continued for one year.

The Committee approved the resolution introduced by Dr. Orrin Sage Wightman of New York providing for the appointment by the Board of Trustees of a Committee on Visual Moving Picture Education.

The recommendations of the Reference Committee on Legislation and Public Relations were adopted by the House of Delegates.

Amendments to Constitution and By-Laws

The Reference Committee on Amendments to the Constitution and By-Laws recommended that the proposed amendment to Section 1, Article 5 of the Constitution, offered by Dr. George Edward Follansbee of Ohio, be made instead an amendment to the By-Laws to be Section 12, Chapter XI, to read as follows:

The House of Delegates shall have the power to expel a member of the American Medical Association or a Fellow of the Scientific Assembly on recommendation of the Judicial Council.

The Committee offered the following substitute for an amendment to Article 12 of the Constitution offered by Dr. J. C. Litzenberg of Minnesota:

The House of Delegates may amend this Constitution at any annual session, provided the proposed amendment shall have been introduced at the preceding annual session, and provided two-thirds of the voting members of the House of Delegates registered at the session at which action is taken vote in favor of such change or amendment.

The Reference Committee recommended that a change in the By-Laws proposed by Dr. J. C. Litzenberg of Minnesota should be changed so that Section 5, Chapter II of the By-Laws shall read:

SECTION 5.—*Quorum.*—Fifty of the voting members of the House of Delegates shall constitute a quorum.

The Committee recommended that a proposed amendment providing that decisions of the Judicial Council should be subject to review by the House of Delegates be rejected.

A proposed amendment to the By-Laws providing for the establishment, maintenance, custodianship and disbursement of special funds by sections of the Scientific Assembly was tabled.

The Reference Committee's recommendation concerning an amendment to the By-Laws, proposed by Dr. Southgate Leigh, to insure representation for constituent associations at the sessions of the House of Delegates was that Dr. Leigh should present the matter in more specific form at the next annual session of the House of *Delegates.*

The recommendations of the Reference Committee on Amendments to the Constitution and By-Laws were adopted by the House of Delegates, except the recommendation concerning the proposed amendment providing for the establishment and disbursement of special funds by sections of the Scientific Assembly which was laid on the table.

Report of Officers

The Reference Committee on Reports of Officers endorsed the opinion expressed by the Speaker of the House that the Speaker's address should be confined to recommendations concerning the conduct and administration of the business of the House of Delegates.

The Committee did not approve the suggestion offered by the Speaker that the details of the work of the House of Delegates should be published in full, but did approve the suggestion of the Speaker that endorsements of recommendations and reports should be made by the reference committees only after thorough review and consideration of all matters referred.

The Reference Committee offered its approval of the declaration of the President that "the time has come when no institution or clinic should permit its attending physicians to be imposed on; and when, whatever the social or other advantage to the physician in the clinic, he should not be permitted to contribute to what is a gross injustice to the profession as a whole."

The Committee also approved the principle of the President's recommendation for the investigation and classification of medical charities through the Judicial Council.

The Reference Committee especially approved of the suggestions of the President-Elect that in the multiplicity of independent medical societies there exists a danger of diverting and dissipating the fundamental strength of organized medicine "as typified in the composition of our county, state and national organizations."

The recommendations of the Reference Committee on Reports of Officers were adopted by the House of Delegates.

Reports of Board of Trustees and Secretary

The Reference Committee on the Reports of the Board of Trustees and Secretary endorsed that part of the Secretary's report relative to the multiplicity of existing independent medical organizations whose work, in many instances, parallels the work of the component county and constituent state medical associations and, to some extent, tends to interfere with the successful operation of component county medical societies and constituent state medical associations of the American Medical Association.

Concerning the meetings of hospital staffs, the Committee offered the following statement:

The committee deprecates especially the compulsory multiple scientific meetings of hospital staff organizations. These have tended to limit to small groups the dissemination of medical information and the discussion of medical problems, interfering thereby with the work of organized medical societies. Organization is necessary in order to obtain unified action of the medical profession in various communities. We feel that the need is greater than ever for general discussion of medical problems and for the dissemination of information associated with the specialties to all physicians. Only in this way can the general practitioner keep abreast of modern medicine.

Your reference committee suggests that the staff meet-

ings of hospitals be devoted preferably to executive discussions of problems relating to hospital economics and records, and that members of the American Medical Association make special efforts to stimulate interest in, and the development of, scientific medicine in the regularly organized county medical societies.

This part of the Committee's report evoked extensive discussion but was adopted by the House as presented by the Committee.

The recommendations offered by the Secretary concerning relief for needy physicians, which recommendations were submitted in compliance with specific instructions received from the House of Delegates, were approved by the Reference Committee with the recommendation that each constituent state medical association should be left to follow its own plan for the relief of needy physicians. After considerable discussion, this matter was referred back to the Reference Committee.

Later on in the session, the Committee reported on a resolution presented by Dr. J. Richard Kevin of New York providing that a committee of the House of Delegates cause to have made survey through county medical societies to gather additional information concerning the need for the establishment and maintenance of a national home for incapacitated or indigent physicians. The recommendation of the Reference Committee was that the Board of Trustees should appoint a commission of five to consider the whole situation, including the various solutions that have been proposed, and to determine the responsibility of the American Medical Association.

The Reference Committee expressed appreciation for the work accomplished by the Board of Trustees. It commended the Quarterly Cumulative Index Medicus and strongly urged that the members and Fellows of the Association should give adequate support to this publication. The activities of the Co-operative Medical Advertising Bureau were endorsed by the Committee and expression was given to the hope that the few state journals which do not participate in the work of this Bureau will eliminate the advertising of products which do not have the approval of the Council on Pharmacy and Chemistry.

The report of the Reference Committee stressed the importance of the periodic examination; commended the work of the Council on Pharmacy and Chemistry, and made an urgent appeal for the support of this Council by the profession at large; approved the work of the Council on Physical Therapy, especially in providing for the dissemination of information concerning the methods of physical therapy among the profession, and commented most favorably on the work of the Bureau of Investigation.

Efforts of the Bureau of Legal Medicine and Legislation toward preventing the extension of socialized medical practice by the government through the Veterans' Bureau and similar organizations were endorsed by the Committee, and the intention of this Bureau to continue its work for legislation, giving physicians the right to deduct from income tax returns expenses incurred in attending scientific meetings and in taking graduate courses of instruction, were approved by the Committee. The activities of the Bureau with respect to the status of the physician as an expert witness were also approved.

The report of the Advisory Committee on Trachoma Among the Indians was endorsed by the Reference Committee, and the continuance of this Committee was recommended.

It was urged by the Reference Committee that members of the House of Delegates should take advantage of every opportunity to keep the component societies of the state associations they represent advised about the work of the American Medical Association.

The Reference Committee expressed appreciation of the report of the Committee on the Grading of Nursing Schools, and recommended that the request for additional appropriations for the use of this committee be referred to the Board of Trustees.

The action of the Board of Trustees advising the rejection of the offer of the Physicians' Home, Inc., to the effect that this home be taken over by the Association was endorsed by the Reference Committee.

The Reference Committee expressed interest in the growth and work of the Woman's Auxiliary, and endorsed the continuance of the annual conferences on public health. The continued extension of the activities of the Association were favorably commented on in the report of the Reference Committee, and the plans of the Board of Trustees for providing increased facilities were approved.

The recommendations of the Committee were adopted by the House.

Reapportionment of Delegates

On recommendation of the Reference Committee on Reapportionment of Delegates, 775 was established as the basic figure for determining representation of state associations. Thus, each constituent state medical association will have one delegate for each 775 members. Each association with a membership of less than 775 will be represented by one delegate. On this basis, the total membership of the House of Delegates will be 173. California, Florida, New Jersey, New York and Pennsylvania will each gain one delegate, under the new apportionment, while Iowa and Texas will each lose one delegate.

Committee on Visual Moving Picture Education

A resolution introduced by Dr. Orrin Sage Wightman of New York provided for the appointment of a committee on visual moving picture education whose duties shall be to deal with the problem of using moving pictures for educational purposes. This resolution was adopted.

Election of Officers

The following officers were elected:

President-Elect, Dr. M. L. Harris, Chicago; Vice-President, Dr. W. A. Jones, Minneapolis; Secretary, Dr. Olin West, Chicago; Treasurer, Dr. Austin A. Hayden, Chicago; Speaker of the House of Delegates, Dr. F. C. Warnshuis, Grand Rapids, Michigan; Vice Speaker, Dr. Allen H. Bunce, Atlanta, Georgia; members of the Board of Trustees, Dr. J. H. Walsh, Chicago, and Dr. A. R. Mitchell, Lincoln, Nebraska; members of the Judicial Council, Dr. F. W. Cregor, Indianapolis, and Dr. James B. Herrick, Chicago; member of the Council on Scientific Assembly, Dr. Roger S. Morris, Cincinnati; member of the Council on Medical Education and Hospitals, Dr. Reginald Fitz, Boston.

Portland, Oregon, was chosen as the place of meeting for the annual session in 1929.

The total registration at the Minneapolis Session was 4,876.

CORRESPONDENCE

BABY WITHOUT ARMS

Lafayette, Indiana,
June 22, 1928.

Editor of THE JOURNAL:

I was most interested in the account of the "Baby Without Arms" as reported by Dr. Price of Nappanee, but he did not have the "only pebble on the beach." Some time about the middle of 1870, Dr. William Orth showed me one he had delivered a few days before. Like the one reported by Dr. Price, it was a girl, perfect in all but the limbs. By manipulation I had no difficulty in locating the empty acetabulum and glenoid cavities. I did not weigh or measure it, but the baby was normal in other respects and would weigh seven or eight pounds.

It was a vertex presentation, the mother, seventeen years old, and had no husband. I did not see it again, but the doctor kept me posted as to the outcome. At

about six months of age the baby developed cholera infantum and fortunately death took her to the Better Land.

Respectfully,
GEORGE F. BEASLEY, M.D.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books Received Since June 1:

HAY-FEVER AND ASTHMA. Their Cause, Prevention and Treatment. By Ray M. Balyeat, M.A., M.D., F.A.C.P., Instructor in Medicine and Lecturer on Allergic Diseases in the University of Oklahoma Medical School. Illustrated with 76 engravings, 2 in colors. Second edition, revised and enlarged. 310 pages. Cloth. Price, $3.50. F. A. Davis Company, publishers, Philadelphia, 1928.

NURSES, PATIENTS AND POCKETBOOKS. Report of a Study of the Economics of Nursing Conducted by the Committee on the Grading of Nursing Schools. By May Ayres Burgess, Director. 618 pages. Cloth. Price, $2.00. Published by Committee on the Grading of Nursing Schools, New York, 1928.

OPERATIVE SURGERY. By J. Shelton Horsley, M.D., F.A.C.S., attending surgeon, St. Elizabeth's Hospital, Richmond, Virginia. Third edition. 756 original illustrations. 894 pages. Cloth. Price, $15.00. The C. V. Mosby Company, St. Louis, 1928.

DISEASES OF THE THROAT, NOSE AND EAR. By Dan McKenzie, M.D., F.R.C.S.E., surgeon, Central London Throat and Ear Hospital, etc. Two volumes. Second edition. 678 pages, illustrated. Cloth. Price, for the two volumes, $17.00. C. V. Mosby Company, St. Louis, 1928.

THE DUODENUM. Medical, Radiologic and Surgical Studies. By Pierre Duval, Jean Charles Roux and Henri Beclere of the Surgical Clinic, Faculty of Medicine, Paris. Translated by E. P. Quain, M.D. 212 pages, profusely illustrated. Cloth. Price, $5.00. The C. V. Mosby Company, St. Louis, 1928.

A HANDBOOK OF CLINICAL GYNECOLOGY AND OBSTETRICS. By Rae Thornton LaVake, A.B., M.D., F.A.C.S., Assistant Professor of Obstetrics and Gynecology, University of Minnesota; Clinician in charge of the Obstetric and Gynecologic Department of the University of Minnesota Dispensary. 281 pages, illustrated. Cloth. Price, $4.00. The C. V. Mosby Company, St. Louis, 1928.

DIATHERMY. Its Production and Uses in Medicine and Surgery. By Elkin P. Cumberbatch, M.A., B.M., D.M.R.E., M.R.C.P. Medical officer in charge, electrical department, St. Bartholomew's Hospital, etc. Second edition. 332 pages, illustrated. Cloth. Price, $7.00. C. V. Mosby Company, St. Louis, 1928.

SYPHILIS. A Treatise on Etiology, Pathology, Symptomatology, Diagnosis, Prognosis, Prophylaxis and Treatment. By Henry H. Hazen, A.M., M.D., Professor of Dermatology and Syphilology, Medical Department of Georgetown University. Second edition. 644 pages, with 165 illustrations, 16 figures in colors. Cloth. Price, $10.00. The C. V. Mosby Company, St. Louis, 1928.

MODERN METHODS OF TREATMENT. By Logan Clendening, M.D., Associated Professor of Medicine, Lecturer on Therapeutics, Medical Department of the University of Kansas. Chapters on special subjects by H. C. Anderson, M.D.; J. B. Cowherd, M.D.; H. P. Kuhn, M.D.,; Carl O. Rickter, M.D.; F. D. Neff, M.D.; E. H. Skinner, M.D., and E. R. DeWeese, M.D. Second edition. 815 pages. Cloth. Price, $10.00. C. V. Mosby Company, St. Louis, 1928.

THE INTERNATIONAL MEDICAL ANNUAL. A year book of Treatment and practitioner's Index. Edited by C. F. Coombs, M.D., F.R.C.P., and A. R. Short, M.D., B.Sc., F.R.C.S. Forty-sixth year, 1927. 574 pages. Cloth. Price, $6.00. Printed in England. William Wood and Company, New York, 1928.

THE GLANDS REGULATING PERSONALITY. By Louis Berman, M.D., Associate in Biological Chemistry, Columbia University. Second edition, revised. 342 pages. Cloth. Price, $3.50. The MacMillan Company, New York, 1928.

COLLECTED PAPERS OF THE MAYO CLINIC AND MAYO FOUNDATION. 1927. Volume xix. Edited by Mrs. M. H. Mellish and H. Burton Logie, M.D. 1330 pages with 412 illustrations. Cloth. Price, $13.00. Philadelphia and London: W. B. Saunders Company, 1928.

CLINICAL MEDICINE. By Oscar W. Bethea, M.D., Ph.G., Professor of Therapeutics, Tulane Graduate School of Medicine; professor of Clinical Therapeutics, Tulane School of Medicine, New Orleans. 700 pages. Cloth. Price, $7.50. W. B. Saunders Company, Philadelphia and London, 1928.

ADDRESS ON SURGICAL SUBJECTS. By Sir Berkeley Moynihan, Bart., President of the Royal College of Surgeons of England. Octavo of 348 pages, illustrated. Philadelphia and London: W. B. Saunders Company, 1928. Cloth. Price, $6.00.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1927. Cloth. Price, postpaid, $1.00. 103 pages. American Medical Association, Chicago, 1928.

NEW AND NONOFFICIAL REMEDIES, 1928, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1928. Cloth. Price, $1.50. 489 pages. American Medical Association, Chicago, 1928.

SYPHILIS. By Henry H. Hazen, A.M., M.D., Professor of Dermatology and Syphilology, Medical Department of Georgetown University. Second edition. 644 pages with 165 illustrations, some in colors. Cloth. Price, $10.00. The C. V. Mosby Company, St. Louis, 1928.

The first edition of this work was one of the best and most comprehensive treatises on the subject of syphilis. The author says that the second edition represents practically an entirely new book inasmuch as nearly all the subject matter has been rewritten and brought up to date. The discussion can be considered authoritative and entirely trustworthy. The various phases of the disease are discussed in different chapters and even the lesions of special tissues and organs are discussed separately. The final chapters discuss diagnosis, prognosis, prophylaxis, etc., in a most instructive manner. We highly recommend the book as worthy of the attention of any practicing physician whether he be general practitioner or specialist.

DISORDERS OF THE NOSE, THROAT AND EAR. By Aaron Roth, M.D., F.A.C.S., attending ear and throat surgeon, Jewish Hospital, Brooklyn. 238 pages. Illustrated by the author. Cloth. Price, $2.50. Physicians and Surgeons Book Co., Brooklyn, 1927.

While the author dedicates his book "to the physicians of the world who are always governed by the spiritual ideals of the practice of their art," yet he admits that the book is designed for the layman and the educator. We think it may be useful to the student as auxiliary reading, and to nurses and general assistants associated in the specialty of otolaryngology. It is of little use to the physician who needs something more comprehensive. He presents the essential facts pertaining to the mechan-

ism of the organs of smell, voice and hearing, and points out the general functions of those structures under normal and abnormal conditions. He also indicates some of the natural processes of healing and the scientific principles of prevention and repair. The textbook is written in simple and non-technical English and no doubt will find a place where intended.

MODERN METHODS OF TREATMENT. By Logan Glendening, M.D., Associate Professor of Medicine, Lecturer on Therapeutics, Medical Department of the University of Kansas. With chapters on special subjects by Drs. Andersson, Cowherd, Kuhn, Rickter, Neff, Skinner and DeWeese. Second edition. 814 pages. Cloth. Price, $10.00. C. V. Mosby Company, St. Louis, 1928.

This is the second edition of a well known and popular work. It represents a complete revision of the first edition in order to bring the work up to date. New subject matter has been added, and some of the chapters on therapy have been radically altered. An effort has been made to present the best modern thought in practice about treatment of diseases included in the general specialty of internal medicine. Throughout the entire text an effort has been made to keep in mind the problems of the general practitioner and encourage him to adopt and use methods which he is likely to believe are effective only in the hands of what the world has unfortunately come to call specialists. The book is very practical and will be found valuable in the library of every practicing physician.

LOCAL ANESTHESIA. By Geza de Takats, M.D., Assistant professor of Surgery, Northwestern University School of Medicine, Chicago. Introduction by Allen B. Kanavel, M.D., Professor of Surgery, Northwestern University School of Medicine. 221 pages with 117 illustrations. Cloth. Price, $4.00. W. B. Saunders Company, Philadelphia and London, 1928.

No excuse need be offered for the presentation of a book on local anesthesia in view of the usefulness and growing popularity of local anesthesia in practically all branches of surgery. That its application should be more general than it is at present no one will gainsay, and as the author well says, "conservatism is justifiable, but not a conservatism that does not take account of a method that is effective in operative surgery and attended by fewer complications and by lower mortality rates than in general anesthesia." The author has had a very large personal experience and is well qualified to present the subject. He discusses the question of how local anesthesia may be used to the best advantage, indicates the most effective method of administration, and suggests how complications may be avoided. He has covered his subject thoroughly and clearly, and his book deserves the appreciation which surgeons no doubt will give it.

DIAGNOSIS OF DISEASE. By Hobart A. Hare, M.D., B. Sc., LL.D., Professor of Therapeutics and Diagnosis in the Jefferson Medical College of Philadelphia; physician to the Jefferson Medical College Hospital, etc. Ninth edition, thoroughly revised. 528 pages, illustrated. Cloth. Price, $5.50. Lea and Febiger, Philadephia, 1928.

Little need be said concerning this ninth edition of a well known and popular book. As the author well says, one of the difficulties of the young physician is that he has been taught how to make a diagnosis in the laboratory but not at the bedside. This volume is intended to teach the young physician how to make a bedside diagnosis or a diagnosis from the symptoms of disease, for when all is said and done a careful study of the patient is usually the chief method by which a correct diagnosis may be made. The well-trained physician carefully notes the symptoms, gives to each its proper value, and if needs be, makes his laboratory investigations afterwards. The author has stuck to his plan of presenting a method of upbuilding the diagnosis by grouping the symptoms. The work is a splendid discussion of the subject, and worthy of the general approval that has been given it.

HAY FEVER AND ASTHMA. By Ray M. Balyeat, M.A., M.D., F.A.C.P., Instructor in Medicine and Lecturer on Allergic Diseases in the University of Oklahoma Medical School. Second edition, revised and enlarged. 310 pages, illustrated. Cloth. Price, $3.50. F. A. Davis Company, Philadelphia, 1928.

This is a revised edition of an excellent work covering a study of asthma, hay-fever and allied diseases. In this edition attention is called to the reasons for failure to accomplish satisfactory results in the treatment of hay-fever, due in many instances to the heretofore unrecognized fact that some cases of hay-fever are not due to pollen in the prevailing neighborhood but to pollen that has been wind-borne from perhaps long distances. Another factor of importance is the knowledge that pollen and other substances to which the patient becomes particularly sensitive differ greatly in various sections of the United States, and unless this is recognized treatment is discredited because ineffective. In reality it is the failure to recognize this fact which makes inefficient the simplified pollen treatments recommended by so many biological houses. The "shot-gun treatment' of asthma and hay-fever will not work, and the author attempts to give helpful suggestions concerning a scientifically planned treatment which offers promise of results. The book is very readable as well as timely.

ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1927. Cloth. Price, postpaid, $1.00. 103 pages. American Medical Association, Chicago, 1928.

The Council on Pharmacy and Chemistry of the American Medical Association annually publishes the reports which tell the reasons for non-acceptance of those products which during the, year it has found unworthy of recognition. Some of these reports have been published in abstract in THE JOURNAL; all are contained in full in the volume which is the subject of the present review. The physician who has learned to ask the manufacturer's "detail" man, "If it is not in New and Nonofficial Remedies, why is it not?" will find here the answer which that personage will no doubt hesitate to give him. The book shows the practical working out of the principles which the Council's experience has shown to be essential in its fight for rationality in the field of proprietary medicines.

Among the products reported as unacceptable are: Bismogenol, which is bismuth salicylate under a fancy name; Desitin, a complex mixture from Germany; Hexol, a pine oil preparation for which unwarranted claims are made; Warnink's Advocaat, a mixture of potassium arsenite and alcohol in the form of an egg nog marketed without emphasis of the arsenic content in a way likely to lead to harmful and ill advised use by the public; and Solvo Aspirin, another futile attempt to market a solution containing acetylsalic acid rendered soluble by addition of sodium bicarbonate.

A glance at the index shows, however, that these reports do not always deal with articles that have been actually rejected by the Council. Preliminary reports are frequently made on new products which appear promising but for which there is not yet sufficient evidence to warrant inclusion in New and Nonofficial Remedies. Included in this group this year are: a report on Blueberry Leaf Extract, which gives promise of being useful in the treatment of diabetes; a report on "Plasmoquin," a substitute for quinine in the treatment of malaria brought out in Germany but thus far withheld from the market by the American agent; a report on "Alpha-Lobeline,"

which has been the subject of many conflicting estimates but which lacks conclusive evidence demonstrating its usefulness; two reports on Ephedrine, announcing standards, evaluating therapeutic usefulness, and finally announcing the acceptability of the drug and of two of its salts; a report on Bismarsen, a new derivative of arsphenamine containing bismuth and proposed for use in the treatment of syphilis.

Of much current interest is the reprint of the report of Dr. R. A. Hatcher reviewing the literature on the Gwathmey method of colonic anesthesia and evaluating the present standing and usefulness of this method. This report is an outstanding example of the way in which the Council in addition to its other activities aims to contribute to the advance of general medical knowledge.

NEW AND NONOFFICIAL REMEDIES, 1928, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on January 1, 1928. Cloth. Price, postpaid, $1.50. Pp. 489 XLIX. Chicago, American Medical Association.

This book is the work of a distinguished organization, the Council on Pharmacy and Chemistry of the American Medical Association, which some twenty years ago was founded to clean out the Augean stables of proprietary medicines. The Council's plan was and has been the publication annually of a book containing descriptions of those unofficial preparations which after careful investigation have been found worthy of recognition and consideration by the medical profession. Such has been the devotion of the Council members, who serve without remuneration, and such the recognition achieved by their work that today the book describes all the new proprietary products which have a scientific base and which give promise of therapeutic usefulness. The physician who best safeguards his own interests as well as those of his patient will give no consideration to any proprietary medicinal agent which is not listed in New and Nonofficial Remedies.

The book is conveniently arranged for reference: each preparation is classified, and each classification is preceded by an authoritative and up to date discussion of the composition, actions, uses, and dosage of the medicament involved. Annually the book is carefully scrutinized and revised to ensure its being in the forefront of medical progress. Products that have been admitted are re-examined at stated intervals to determine if they are keeping their promise of therapeutic usefulness; and new products are admitted as they are found acceptable.

Among the more important revisions this year are: the rewriting or recasting of the chapters on Medicinal Foods, Insulin, Arsenic Compounds, and Iron and Iron Compounds; revision of the chapters on Ovary and Parathyroid to make them conform to the results of recent research; and revision of the names and standards of the acriflavine dyes. A noteworthy omission is that of all parathyroid gland preparations designed for oral administration, their lack of efficacy by this route having been conclusively demonstrated.

The following are some of the products which have been recognized during the past year and which are now included in the book: Neonal, a new barbital compound; Mesurol, a bismuth preparation for use in the treatment of syphilis; Bromural, once omited from the book, but now reinstated as a result of the manufacturer's limitation of therapeutic claims; a number of standardized cod liver oils; Ephedrine, an alkaloid with epinephrine-like properties, and its hydrochloride and sulphate salts; Amiodoxyl benzoate, the ammonium salt of orthoiodoxy-benzoic acid, proposed for the treatment of arthritis; Crotalus Antitoxin, an antisnakebite serum; several brands of erysipelas streptococcus antitoxin; and Anaerobic Antitoxin, and antitoxic serum for use against gas gangrene.

On account of the careful revisions and the current additions, New and Nonofficial Remedies is essentially a new book each year, indispensable to the physician who would keep us with the march of therapeutic progress.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

ETHYLENE-CHENEY.—A brand of ethylene for anesthesia—N.N.R. (New and Nonofficial Remedies, 1928, p. 51). The Cheney Chemical Co. (*Jour. A. M. A.*, May 5, 1928, p. 1444).

LIPIODOL-LAFAY.—Iodized Poppy-seed Oil 40 per cent.—An iodine addition product of poppy-seed oil containing 39 to 41 per cent of iodine in organic combination. Lipiodol-Lafay is used as a contrast medium in myelography and pyelography, for detecting urethral strictures, in the spinal column for detecting tumors, and in other conditions for which roentgenologic exploration is desired. It is supplied in ampoules containing 1, 2, 3 and 5 cc. respectively. E. Fougera & Co., New York.

LIPIODOL RADIOLOGIQUE DESCENDANT. — Iodized Poppy-seed Oil 35 per cent.—An iodine addition product of poppy-seed oil containing 34 to 36 per cent of iodine in organic combination. In subarachnoid injection for roentgenray examination, lipiodol radiologique descendant is used for the recognition of intradural tumors. E. Fougera & Co., New York.

LIPIODOL RADIOLOGIQUE ASCENDANT—Iodized Poppy-seed Oil 10 per cent.—An iodine addition product of poppy-seed oil containing 9.8 to 11.2 per cent of iodine in organic combination. In subarachnoid injection for roentgenray examination, lipiodol radiologique ascendant is used for recognition of intradural tumors when it is desired to employ a contrast medium of lesser density than that of the spinal fluid. E. Fougera & Co., New York.

MEAD'S POWDERED BOILABLE PROTEIN MILK. — A modified milk preparation having a relatively high protein content and a relatively low carbohydrate content. Each 100 Gm. contains approximately protein, 39 Gm.; butter fat, 27 Gm.; lactose, 24 Gm.; free lactic acid, 2 Gm.; ash, 6 Gm.; and moisture, 2 Gm. When suitably mixed with water, powdered boilable protein milk is useful for correcting intestinal disorders of infants and children. Mead Johnson and Company, Evansville, Indiana.

ANTIRABIC VIRUS (SEMPLE).—A phenol killed antirabic vaccine prepared according to the general method of David Semple (New and Nonofficial Remedies, 1928, p. 363). It is marketed in packages of fourteen doses, each dose consisting of 2 cc.; all the doses are of the same potency. Pasteur Institute of St. Louis, St. Louis. (*Jour. A. M. A.*, May 19, 1928, p. 1627).

STEARODINE.—CALCIUM IODOSTEARATE.—It contains from 26 to 28 per cent of iodine in organic combination. Stearodine is used as a substitute for the inorganic iodides, over which it is claimed to have an advantage in that it is longer retained and therefore better utilized. See Iodized Fats and Fatty Acids, New and Nonoffiicial Remedies, 1928, p. 212. Stearodine is also supplied in the form of tablets, each containing stearodine, equivalent to 0.01 Gm. of iodine. Parke, Davis & Co., Detroit. (*Jour. A. M. A.*, May 26, 1928, p. 1711).

PROPAGANDA FOR REFORM

ETHYLENE-CHENEY.—The American Medical Association Chemical Laboratory publishes a further report on specimens of ethylene for anesthesia examined for the Council on Pharmacy and Chemistry. Its previous reports concerned the products of the Ohio Chemical and Manufacturing Co., Kansas City Oxygen Gas Co. and Certified Laboratory Products Co. These products were found of good quality and have been accepted for

New and Nonofficial Remedies. The present report is on the ethylene for anesthesia of the Cheney Chemical Co., Cleveland, Ohio. The first specimens were found to contain some acetylene. When the laboratory's findings were sent to the manufacturer, the firm took steps to supply a product which should be free from acetylene and submitted a specimen that was free from acetylene and complied with the New and Nonofficial Remedies standards for ethylene for anesthesia. (*Jour. A. M. A.*, May 5, 1928, p. 1444).

Patent Medicines in Mexico.—The health department of Mexico has prohibited the sale of such "patent medicines" as "Wine of Cardui," "Peruna," "Tanlac," "Pinkham's Blood Purifier," "McCoy's Cod Liver Oil Tablets" and "Miles' Heart Tonic." The reason for this prohibition is thought to be the fact that the manufacturers are alleged to have failed to comply with the regulations recently put into effect by Mexico, requiring all "patent medicines" to publish a statement of their formulas on trade packages. (*Jour. A. M. A.*, May 5, 1928, p. 1480).

The Cunningham "Tank Treatment."—Dr. Orval J. Cunningham of Kansas City, Mo., has been treating certain pathologic conditions by means of compressed air over a period of some years. In Kansas City he has constructed a cylindrical tank about ten feet in diameter and nearly ninety feet in length. The tank is said to be equipped with air lock, toilets, shower baths, compartments, and Pullman car equipment. Newspapers report that a tank is to be constructed in Cleveland. Advertising for a concern that was to operate the Cunningham "treatment" in California declared, "it now appears positively proven that syphilis, pernicious anemia and diabetes are curable by this method. . . ." Dr. Cunningham's thesis is that diabetes mellitus, pernicious anemia, syphilis, hypertrophic arthritis and carcinoma are all due to bacteria of an anaerobic type. He holds, further, that the oxygen content of the tissues is greatly increased when the patients are put in his compressed-air tank and that the compressed air treatment is curative in certain cases of diabetes mellitus, pernicious anemia, hypertrophic arthritis, syphilis and carcinoma. The status of the "tank treatment" is obvious; Dr. Cunningham claims unusual results for his treatment but has published no case reports nor furnished the medical profession with any evidence to support the claims. His thesis is altogether without proof. (*Jour. A. M. A.*, May 5, 1928, p. 1494).

Fake Cod Liver Oil Tablets in England.—In the city of Salford, England, there was sold at a large chain drug store "McCoy's Cod Liver Oil Extract Tablets." The town of Salford proceeded against the store in question, prosecuting it for selling cod liver oil tablets that were essentially misbranded. Chemical and biologic tests showed that McCoy's Cod Liver Oil Extract Tablets contained neither vitamin A nor vitamin D, and that, medicinally as a substitute for cod liver oil, the tablets were worthless. (*Jour. A. M. A.*, May 12, 1928, p. 1575).

Armstrong's Oxycatalyst.—The Radium Research Foundation, Los Angeles, California, offers a treatment for cancer, the "Armstrong Oxycatalyst." The Radium Research Foundation also puts out a product known as "Radium-Sol" which is reported to be "the great gland activator and oxygenizer of the blood." This, it seems, is a "patent medicine." A recent article in a California newspaper purports to be a report of an interview with Mr. Armstrong regarding the Armstrong Oxycatalyst. A second article purports to be a report of interviews with Dr. Charles M. Tinney and Stanley Boller. Dr. Tinney was reported as declaring that he had personally seen 200 to 300 cases of cancer and that only Mr. Armstrong "knows all the ingredients of the fluid." According to a report of Dr. Tinney, used in the promotion of the "Oxycatalyst," the preparation "is a radium derivative which Prof. Armstrong has combined with a catalyzer." The report takes the position that cancer is "a protein mass in which the sulphur, phosphorus and nitrogen are out of their normal valence and therefore are foreign to the general protein of the body" and that the action of Armstrong's Oxycatalyst is that of dissolving and digesting the cancer mass. While the "Oxycatalyst" is claimed to have a scientific background, it has not been submitted to the Council on Pharmacy and Chemistry for consideration. Although the use of the preparation is admitted to be in the experimental stage, there are agencies for the product and large fees are charged in certain instances for its use. Whether Mr. Armstrong's preparation is an addition to the medical armamentarium in the treatment of cancer or just another "cancer cure," is yet to be determined. (*Jour. A. M. A.*, May 19, 1928, p. 1647).

Explosions of Ethylene.—Several ethylene explosions have been reported but only two have been fatal. The greater number of explosions have been due to electrostatic conditions and have occurred during the winter months. Ethylene is an inflammable gas and should not be used in the presence of a cautery, open flame, or any electrical apparatus capable of producing a spark from any cause. (*Jour. A. M. A.*, May 19, 1928, p. 1650).

Liver in Secondary Anemia.—There is clinical evidence both for and against the effectiveness of liver diet in anemias other than the pernicious type. (*Jour. A. M. A.*, May 19, 1928, p. 1650).

Dextrose Solutions Containing Cresol. — The Council on Pharmacy and Chemistry reports that it has considered a communication objecting to the acceptance for New and Nonofficial Remedies of solutions of dextrose (d-glucose) in ampules containing 0.1 per cent of cresol. It was held that injection of cresol into the blood stream is the cause of many reactions which sometimes follow injection of dextrose solutions containing it. The Council concludes that the harmfulness of cresol in the amounts used in dextrose solutions has not been demonstrated. The Council decided to request manufacturers of dextrose ampules intended for intravenous use to consider the elimination of cresol as a preservative as possibly harmful. (*Jour. A. M. A.*, May 26, 1928, p. 1711).

R. P. N. Tablets.—One of the latest humbugs in the field of epilepsy mail-order quackery is the product called "R. P. N.", put out by the Arpen Laboratories which does business from a postoffice box in Milwaukee, Wisconsin. In the advertising that is sent out the sufferer is led to believe that in R. P. N. Tablets there is a cure for his ailment. The American Medical Association Chemical Laboratory analyzed the preparation and concluded that each tablet is equivalent to 0.2 Gm. ammonium bromide; 0.45 Gm. of sodium bromide; 0.11 Gm. of sodium chloride, and 0.0031 Gm. of potassium bromide. From the analysis it is seen that R. P. N. Tablets belong to the old-time group of quack "epilepsy cures," consisting of mixtures of bromides. The preparation will not cure a case of epilepsy, while, indiscriminately used—as it must be—by persons who are ignorant that it contains bromides, may easily result in adding to the epileptic sufferer's condition the dangers of bromism. (*Jour. A. M. A.*, May 26, 1928, p. 1728).

Poliomyelitis Antistreptococcus Serum. — The Council on Pharmacy and Chemistry publishes a preliminary report on poliomyelitis antistreptococcus serum. The Council reports that the use of a specific antiserum in the treatment of poliomyelitis has been proposed; that a number of reports on the use of such a serum have been published; and that two commercial products, obtained by immunizing horses against strains of streptococcus from poliomyelitis patients, have been submitted to the Council. The Council reports that because of lack of adequate evidence, it had been decided not to accept any poliomyelitis antistreptococcus serum until more positive

(Continued on adv. page xx)

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OPTICAL instruments have become remarkably accurate. Oculists can and do write exceedingly precise prescriptions. Yet, for years, the oculist has realized that if the eye itself did not accommodate for slight errors in the margins of ordinary ophthalmic lenses, oblique vision actually would be blurred.

Tillyer lenses are free from marginal errors—in fact, accurate to the very edge. Furthermore, because of a better finish, Tillyer lenses give a *noticeably* cleaner, brighter definition through the center and, because of their greater accuracy, *hold this definition over the entire surface of the lens.*

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Bifocal wearers make constant use of the margins of their lenses. Tillyer bifocals will greatly benefit them.

New!
Tillyer Lenses
Accurate to the very edge
Patented

TRUTH ABOUT MEDICINES

(Continued from page 320)

evidence for its usefulness becomes available.—(*Jour. A. M. A.*, February 25, 1928, p. 617).

Separation of the Active Principles of the Posterior Lobe of the Pituitary Gland.—Using both methods of fractionation by precipitation and methods of dialysis, two portions of pituitary extract were obtained, one of which responded almost entirely to the oxytocic method of assay whereas another portion was found to respond to the pressor method and practically not at all to the oxytocic. Both of these principles have been obtained in a state of highly potent water-soluble powders. It is reported that the substantially pure pressor principle, termed B-hypophamine, has been obtained as a white powder eighty times as potent as the International Standard Powdered Pituitary, while the oxytocic principle, termed A-hypophamine, has been obtained in a form 150 times as potent as the International Standard Powdered Pituitary. From this research the indications are that the pressor principle is responsible for the diuretic-antidiuretic action of the pituitary extracts. This work will undoubtedly lead to clinical applications of these principles, though at present the work is in an experimental state.—(*Jour. A. M. A.*, February 25, 1928, p. 618).

The "Dr. S. J. Eagan" Fraud.—On December 16, 1927, the Federal Trade Commission issued a "Cease and Desist" order in the matter of Leroy A. Kling, John E. Weddell, William R. Durgin and Cecil Widdefield, said to be co-partners doing business under such trade styles as "Dr. Eagan Manufactory," "Dr. S. J. Eagan." "Dr. Eagan Laboratory," "Pharmaceutical Products, Ltd.," and Kling-Gibson Co. The commission declared that Kling, Weddell, Durgin and Widdefield under the various "Dr. Eagan" trade-styles were engaged in the business of selling cosmetics, creams, lotions and other toilet preparations on the mail-order plan. The Kling-Gibson Co., an advertising agency, was charged with composing and preparing advertisements for the various quackeries exploited under the names "Dr. S. J. Eagan," "Dr. Eagan Laboratory," etc. The commission declared, further, that in the advertisements of these enterprises were many false, fraudulent and misleading statements made with the intent of deceiving the public. The case of the Eagan quackery is of more than ordinary interest to those who believe in truthful advertising.—(*Jour. A. M. A.*, February 25, 1928, p. 635).

"Colloidal Gold."—"Colloidal Gold" was developed by Professor Louis Kahlenberg and Dr. Edward H. Ochsner. It is claimed that the remedy has proved far superior to the roentgen ray and radium in the treatment of inoperable cases of cancer and also as a postoperative treatment. The Council on Pharmacy and Chemistry examined the evidence and reported in 1925 that there was no reason for believing that "Colloidal Gold" offers anything more in the treatment of carcinoma than do the other colloidal preparations that have preceded it. From the circular matter that is sent out for Collodaurum by the Kahlenberg Laboratories, Inc. (successor to the Kahlenberg-Klaus Co.) it appears that this is essentially the same as the product formerly marketed as "Colloidal Gold." Further observations on the use of "Colloidal Gold" which have been published do not seem to permit a revision of the Council's estimate of the product. On the contrary, the new reports strengthen the Council's decision.—(*Jour. A. M. A.*, February 18, 1928, p. 564).

Page Noah Webster

Colored Customer—"Ah want a quote of sanctified milk."

Storekeeper—"What you-all mean is pacified milk."

Customer—"Look heah, small one, when Ah needs inflammation, Ah'll specify."—*Gateway to Health.*

"Do I understand you to say that you believe in vaccination, Mrs. Ropiestere?"

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ORIGINAL ARTICLES

THE TREATMENT OF HEAD INJURIES

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Injuries to the skull and brain constitute a type of trauma that is becoming more and more frequent, due largely to the increasing number of automobile accidents. As such accidents may occur in any locality it is incumbent upon every physician to acquaint himself with the principles of diagnosis and treatment of these emergencies. While there may be a slight difference of opinion between surgeons treating this type of injuries in regard to certain details, on the whole there is a striking unanimity of opinion as to the essential points. In fact, we may consider that at the present time the treatment of head injuries is practically a standardized procedure. Moreover, this procedure in most cases is simple, can be carried out by general practitioner, and does not require skill in neuro-surgery. In fact, only a small percentage of head injuries require operation other than the repair of a scalp wound.

There is a large group of head injury cases that will die regardless of the treatment employed. There is another group that will get well without treatment. But there is a middle group, probably the smallest of the three, the outcome of which depends largely upon the treatment employed. As it is impossible to determine to which group a certain case belongs until it is carefully studied, it is very essential to determine as accurately as possible the true nature and extent of the underlying pathology.

On encountering a case of head injury the following pathological possibilities must be considered. One or all of these conditions may be present in the same patient.

The presence of scalp wounds and haematomata of the scalp and subperiosteal space are self-evident, yet one must always determine whether or not there is a fracture of any type beneath a scalp wound, or a depressed fracture under a haematoma.

Fractures of the skull of themselves are of minor importance compared to the injury to the underlying brain. Large and multiple fractures may occur with mild brain disturbance, while in other cases of head injury there may be no fracture but grave intracranial disturbance possibly leading to death. Occasionally the extent of the skull fracture may indicate the severity of the external violence, which in turn will give an idea as to the insult to the brain; but as a rule the determination of the presence of a fracture or its extent is of little practical value. There are two important exceptions to this, however. First, compound fracture of the skull; and second, depressed fracture of the vault, both of which conditions call for operation as soon as the shock has subsided.

Fractures of the skull have been classified in various ways and certain significance given to certain types. It is a popular belief that fractures of the base are more serious and fatal than fractures of the vault. I do not believe that this is true as far as the injury to the skull or brain is concerned, but in fractures of the base the accessory sinuses and external auditory meatus are often opened, causing the fracture to become compound and making possible the occurrence of meningitis. Fractures through the middle fossa are generally accompanied by hemorrhage and escape of cerebrospinal fluid from the ear. In such a compound fracture infection and meningitis occasionally occur, but this is relatively infrequent.

Fractures of the frontal fossa, which may open into the frontal, ethmoidal, and sphenoidal sinuses, are very prone to infection, and meningitis, generally the pneumococcic type, is a very common occurrence.

In fractures of the skull, therefore, we may dismiss the fracture itself as being unimportant, unless it falls under one of the following types: Depressed fracture of the vault; compound fracture under a scalp wound; fractures of the base when compound through the external auditory meatus or through one of the accessory bony sinuses.

In all head injuries, whether or not the skull is fractured, our chief concern is the condition of the brain. The terminology of brain injuries is not uniform, but for practical purposes we may group these lesions as follows: Cerebral concussion, cerebral contusion and laceration, and cerebral compression. Cerebral oedema generally accompanies each of these conditions.

Cerebral Concussion: By the term "concussion" we designate that condition of the brain in which most of its functions cease following a severe jar. In pure concussion there is absolutely no hemorrhage into or about the brain. Some consider concussion to be simply multiple microscopic contusions of the brain, the difference between concussion and contusion being a difference of degree rather than of kind. Others believe that concussion is due to either a cellular or molecular disturbance of the brain cells and constitutes a distinct pathological entity. The recent extensive studies of Miller[1] make one lean to the view that the two conditions are distinct. However, one must keep in mind that both concussion and contusion may be present in the same injured brain. Miller states: "The term concussion should be used to indicate a group of symptoms which are the result of a temporary inhibition of cortical function, with or without stimulation or inhibition of one or more of the medullary centers, but which are not accompanied by pathological lesions."

The chief clinical features of concussion are, loss of consciousness with an entire absence of localizing cortical signs. Symptoms of medullary disturbance may or may not be present. Cerebral oedema frequently follows concussion. In pure concussion the spinal fluid is absolutely free from blood. The least trace of blood indicates a cerebral contusion. In the great majority of cases concussion is a temporary condition and is followed by recovery. Occasionally the concussion may be so severe as to be followed by death.

Cerebral Contusion and Laceration means that the brain has been either bruised or torn, causing a rupture of brain tissue, either microscopic or gross. This is always accompanied by greater or less hemorrhage into the brain substance, and as the pia mater over the bruised area is generally torn, there will be an escape of blood in the subdural space which will stain the cerebrospinal fluid in proportion to the amount of hemorrhage. An area of cerebral contusion may appear as a dark red or purple spot on the cortex, due to gross hemorrhage within the brain tissue, or it may appear mottled, due to many fine petechial hemorrhaged in the contused area. Either of these findings constitute a mild form of contusion. Depending upon the severity of the violence, various degrees of contusion may occur covering one or both hemispheres, and in extreme cases the cortex may be torn, lacerated, or pulpified. The accompanying hemorrhage is in proportion to the laceration of the brain and pial vessels.

In cerebral contusions and lacerations one point must be kept in mind: that there is no known surgical procedure to repair these damaged areas of the brain. Keeping this fact before us will tend to simplify our treatment.[2]

In the majority of cases of cerebral contusion the contused or lacerated area lies under the area of impact. In a smaller group of cases the contused area is diametrically opposite the point of impact, the so-called contrecoup. Even when the contusion is a contrecoup there is generally a small area of contusion at the point of impact. There is some evidence to indicate that when the head is stationary and is struck by a moving object, the contusion is at the point of impact; and when the moving head, as in falling, strikes a stationary object, the contusion is contrecoup.[3]

As mentioned above, cerebral contusion and laceration is accompanied by more or less subdural hemorrhage, but this bleeding, even when in large amounts, seldom causes severe pressure on the brain. In some cases of excessive bleeding it is necessary to perform a decompression operation, remove the clots, and institute drainage; but with the better understanding of the pathology of brain injuries this type of operation is seldom indicated. (This must not be confused with extradural hemorrhage that requires operation in practically every case).

When one encounters a case of head injury there may be some difficulty in differentiating between concussion and contusion of the brain, but this differentiation is seldom of practical importance. A lumbar puncture will clear this point at once, as a clear fluid indicates concussion, and a bloody fluid shows laceration or contusion; but as there is a considerable element of danger in this procedure, and as the information gained is of little if any aid in treatment, most workers refrain from doing a puncture, especially during the first twenty-four hours after the injury. In some cases the differentiation between concussion and contusion can be made by physical findings. In pure concussion there are absolutely no localizing brain symptoms. The patient is stuporous, or unconscious. Respiration is slow or of the Cheyne-Stokes type. The pulse is slow and occasionally there is a slight rise in blood pressure. All limbs are equally flaccid and there are no convulsions of any type. Occasionally there is a paralysis of the third, sixth, or seventh cranial nerves of one side, due to stretching or contusion of the nerve trunk at its foramen of exit. It is almost inconceivable that a cortical lesion could involve the area of one of these nerves alone.

In cerebral contusion localizing symptoms are often present, especially when the lesion is near the motor cortex. In such cases there may be a flaccid paralysis of a leg or arm, or both; paralysis of one side of the face, and conjugate deviation of the eyeballs. In a wide-spread lesion of the motor cortex there may be a complete haemiplegia of the opposite side. Occasionally spasmodic twitching of a limb or the side of the face may occur, indicating a cortical irritation which is generally due to an increasing hemorrhage over the motor area. In all types of head injury the reflexes are generally totally abolished for

the first twenty-four to forty-eight hours following the injury.

Cerebral Compression following an injury to the head may be due to the following conditions: Oedema following concussion or contusion; hemorrhage into the subdural space secondary to cerebral contusion or laceration; and extradural hemorrhage. The chief seriousness of cerebral compression is the pressure upon the medulla which leads to a slowing of the pulse, a rise in blood pressure, and an embarrassment of the respiration. This latter condition may be so severe as to result in death. Compression secondary to oedema of the brain can generally be controlled by medical means. Subdural hemorrhage is seldom sufficient to require operative relief. But in the case of extradural hemorrhage, a condition that is comparatively rare, an operation for drainage and for the control of the bleeding is indicated as soon as the condition is diagnosed. Most cases of extradural hemorrhage are due to the tearing of the middle meningeal artery secondary to fracture of the middle fossa of the skull. Less frequently there is found a hemorrhage of either a frontal or occipital branch of the meningeal artery. As a rule, the diagnosis of compression from extradural hemorrhage is fairly easy if one is on the lookout for this condition. It may occur in two types of cases: those showing a "lucid interval," and those without a "lucid interval." In the former the patient may show signs of concussion for a few hours and then appear to recover in a satisfactory manner. He may even get up and walk about. After six to eighteen hours, however, he again lapses into unconsciousness and shows all of the signs of increased intracranial pressure, namely, a slow pulse, elevation in blood pressure, and embarrassed respiration. If the hemorrhage is from the middle meningeal artery there may be a sudden complete haemiplegia of the opposite side of the body. In rare instances the hæmiplegia is preceded by mild convulsive movements.

The so-called lucid interval occurring between the two attacks of unconsciousness is due to the fact that it takes a certain length of time for the escaping blood to dissect the dura away from the inner surface of the skull. As a rule, there is an average time of twelve hours before the compression symptoms appear. Rarely, the lucid interval lasts several days. One case in my experience showed the second attack of unconsciousness fourteen days after the injury from a rupture of a frontal meningeal vessel. In this case the bleeding was probably intermittent rather than continuous.

In order that the patient may show a lucid interval the injury to the brain must not be too severe. When the brain injury itself is severe enough to keep the patient unconscious for twelve hours or more we may have the second type of compression coming on without the lucid interval, in which case the diagnosis of cerebral compression is less easily made. Such a patient will show at the onset the signs of concussion or contusion, but by observing the pulse rate, blood pressure, and respiratory rate every thirty to sixty minutes the signs of medullary compression will be noted. A gradual slowing of the pulse with an increase in blood pressure as noted from hour to hour is almost a sure sign of increasing intracranial pressure. Twitching of the muscles of the face or one side of the body, and the finding by x-ray of a fracture through the middle fossa of the skull are additional points of evidence. In these cases of cerebral compression without a lucid interval one may mistake a subdural hemorrhage for an extradural bleeding, but this mistake is of no great moment as a subtemporal decompression is generally indicated as soon as signs of an increasing intracranial pressure manifests itself.

Keeping in mind the above-mentioned pathological facts, we may proceed to discuss in detail the treatment of the various types of head injuries.

The first step is to combat shock. Almost every patient with a head or brain injury suffers more or less shock immediately following the injury. The only difference between this and other types of surgical shock is that in head injuries the patient is generally unconscious, and the pulse rate instead of being rapid is slow, due probably to medullary or vagus pressure. The most important step in treating shock of this type is absolute rest and the application of external heat. If the patient is restless or delirious sedatives must be administered. It is generally considered that codein, alone or combined with one of the hypnotics, is more satisfactory than morphin. As a rule a hypodermic of one-half grain codein every two to four hours will keep the patient quiet. If the codein alone fails, a rectal suppository containing codein grains one-half and trional grains fifteen is often of value, administered every three to six hours. The objection to morphin is that it tends to inhibit the already embarrassed respiration, and in some patients it seems to increase the excitement and restlessness rather than diminish it. In the case of highly delirious patients where the codein and trional fails it may be necessary to resort to morphin, or better, morphin and scopolamin. In extreme cases the patient can be controlled only by restraining sheets.

Bleeding from a scalp wound should be controlled without moving the patient from the bed. This can be done with a few ligatures or a tight compress. Do not attempt to suture the scalp wound while the patient is in shock. If there is bleeding from the external auditory meatus, place a square of sterile gauze over the entire ear and let it bleed. When there is bleeding from the nose or mouth do nothing to stop it. In such cases, however, it is well to keep the patient on his

side so that the blood will flow out of the wound and not be aspirated. It has been frequently observed that patients who bleed freely from the nose, throat, or auditory meatus, provided they do not develop a meningitis, generally do well, as the trauma has performed a decompression. Moreover, I have never heard of a patient bleeding to death from hemorrhage of those orifices following a head injury.

Do not take an x-ray while the patient is in shock. In fact, do nothing while the shock persists but treat this phase of the injury. It is an almost positive fact that any surgical treatment or unnecessary manipulation during the state of shock merely hastens the fatal outcome. Moreover, one can rest assured that if the patient dies before coming out of shock, he would undoubtedly have died sooner if any surgical treatment had been employed.

Cerebral Oedema is a condition the mechanism of which is poorly understood, but we know that oedema follows all types of brain injury almost immediately after the insult. With the onset of the oedema there is an increase in intracranial pressure which, occurring in an unyielding cavity, produces compression on the entire brain. Within recent years we have learned how to reduce this oedema to a certain degree by the method of partial dehydration of the brain. This is done by increasing the osmotic pressure of the circulating blood by introducing hypertonic solutions in the circulation. The method of choice is as follows: As soon as the patient has been made quiet, inject into a vein 50 cc. of a 50 per cent glucose or dextrose solution at the rate of 10 cc. per minute. This solution comes in ampules ready to use as soon as it has been warmed to body temperature. It is easiest given by means of a 50 cc. syringe. Not only does the glucose solution reduce the cerebral oedema, but it also has a beneficial action in helping to reduce the shock. The above-mentioned adult dose should be proportionally reduced for children. If the patient does not respond satisfactorily to the first dose of glucose it is well to repeat it every twelve hours. In case glucose is not available a 30 per cent to 33 per cent salt solution can be used intravenously as the hypertonic agent. Sixty cc. of this solution may be given, but it should not be administered faster than 2 cc. to 3 cc. per minute. Clinical experience indicates that the use of glucose solution is preferable to salt solution. Moreover, one can carry the ampules of glucose in his emergency grip.

If the patient is going to rally from the shock he generally shows improvement, as indicated by the pulse volume, within six to twelve hours after the injury. It is then time enough to obtain x-rays, make a physical examination, and perform any necessary surgery. The results of this study will indicate whether the patient should be treated by medical or surgical means. Aside from the repair of scalp wounds there are just three indications for surgery in head and brain injuries: (1) to prevent infection, (2) to reduce cerebral compression, and (3) to elevate depressed fractures of the vault of the skull. If one of these conditions is not present the patient does not require operation and should be treated solely by medical means. As mentioned above, we are absolutely powerless when it comes to repairing bruised or torn brain tissue, and any operation to expose such a contused area generally adds to the trauma already suffered.

The conditions that indicate an operation to prevent infection are: compound fracture of the vault of the skull, and compound fracture of the frontal fossae that communicate with the frontal, sphenoid, and ethmoid sinuses. Compound fracture in the middle or temporal fossa with escape of blood or cerebrospinal fluid from the external auditory meatus, does not require operation unless the defect in the bone is so extensive as to allow an escape of cerebral tissue through the meatus.

The indications for operation to reduce cerebral compression are positive when we have a second attack of unconsciousness following a lucid interval, which indicates an extradural hemorrhage; also in types of head injury in which the signs of medullary compression gradually increase and which cannot be controlled by other means. Such a state of affairs will mean that we have an extradural hemorrhage without a lucid interval, a severe and extensive subdural hemorrhage, or a very severe degree of cerebral oedema. The latter two conditions, however, are extremely rare.

In depressed fractures of the vault of the skull which are not compound, an operation is indicated in order to elevate the fragments of bone and repair any dural tears, thus preventing at a later date the occurence of severe attacks of headache or Jacksonian epilepsy.

Let us now assume that our patient is out of shock and has been examined and found not to require an immediate operation. We now have two duties to perform; first, the medical care of the patient, and second, careful observation for signs of cerebral compression. The treatment consists in keeping the patient absolutely quiet with codein, etc. It is generally best to keep the patient dehydrated for the first twenty-four hours. Afer this time, if he is unable to take fluids by mouth, the administration of fluids by use of the Murphy drip is indicated, or if this is not tolerated, by the administration of normal salt solution by a vein. If the patient remains unconscious, attempts should be made to reduce the cerebral oedema by the intravenous administration of glucose solution every twelve to twenty-four hours. Patients with brain injury almost invariably have retention of urine so that catheterization at eight-hour intervals is indicated. If

the patient remains unconscious and is unable to take food after twenty-four hours, he should be given a meal twice a day by means of a stomach tube, or better, by a nasal tube. This meal should consist of a raw egg, a glass of milk, and a dram of sugar. It is also well to add an ounce of Epsom salts to this mixture once a day. Aside from the above treatment there is absolutely nothing else to do. Ice-caps to the head are often used, and while they do no harm they probably do no good except to follow the traditional ceremony and satisfy the family. If with the above treatment the patient fails to respond and finally dies, we can rest assured that we have done everything possible considering the present state of our knowledge.

If the patient tends to recover he will gradually regain consciousness. In some cases the return to consciousness is very slow, the patient passing through a period of mental cloudiness or mild delirium. From this stage on the chief treatment is rest and time. Patients who have been unconsciousness only one hour should be kept in bed for at least two weeks, with restricted activity for another two to three weeks. Patients who have been unconscious for twelve hours should be kept in bed for four to five weeks, with one to two months of restricted activity. It is often difficult to make a patient realize the need of rest and quiet after his mind has become clear, so it is very necessary to impress upon him and his family the possibility of the occurrence of prolonged attacks of headache and dizziness and a host of neurotic symptoms if he resumes activity too soon.

During the first twenty-four hours following a head injury the patient should be constantly watched for signs of cerebral compression as shown by an increase in blood pressure of ten to twenty points, a gradually slowing pulse rate, and shallow or irregular respiration. The appearance of Cheyne-Stokes respiration following a head injury is almost positive evidence of increased pressure on the medulla. If these symptons of increased pressure are definite we have the indication for a decompression operation.

Let us now consider briefly those cases requiring surgical treatment.

Scalp Wounds: In all scalp wounds except those made by a sharp instrument by a glancing blow, an x-ray plate should be made to show whether or not there is a fracture of the skull beneath the wound. Compound fractures of the skull have frequently occurred in patients who have had no symptoms of brain injury, and a failure to recognize this type of fracture has often resulted in meningitis and death.

If the skull is found to be normal, the hair should be shaved at least a half-inch about the wound and the wound thoroughly cleansed and freed from all dirt and foreign particles. If the edges of the wound are contused, or if there is dirt ground into the tissues, the edges of the wound should be cut away before suturing. If the wound has been badly contaminated, especially with surface soil or dirt from an automobile, 1500 units of tetanus antitoxin should be given.

Compound Fractures of the Vault of the Skull: The head should be widely shaved around the wound and the wound edges trimmed free of all contused and soiled tissue. When the field is thoroughly cleansed the wound should be enlarged if necessary to expose the entire extent of the fracture. If the fracture is depressed, one can generally insert rongeur forceps under the edge of the normal bone and enlarge the opening in the skull so that the depressed fragments can be lifted out. In most cases the inner surface of the depressed fragments are larger than the outer surface. All loose fragments of bone and any foreign material must be removed and the dura inspected for lacerations. If the dura is found torn the underlying brain must be inspected for penetrating fragments, the removal of which is absolutely essential. The best and safest instrument for exploring the lacerated brain is an old soft catheter of small size. When one is satisfied that all bone and foreign material has been removed, the wound should be gently flushed with normal salt solution. All wiping and sponging of the brain should be done with cotton wet with salt solution. Gauze sponges should never be used. The rent in the dura is next closed with interrupted sutures, without drainage. This is most important to prevent subsequent infection and also brain hernia or fungus cerebri. In case the dura is too badly lacerated to allow satisfactory tight closure, the rough edges should be trimmed away and the defect covered by suturing a properly fitting graft taken from the fascia lata. The scalp is then closed without drainage. If the loss of bone is sufficient to cause a serious defect, this can be remedied at a later date by means of a bone graft.

In case the compound fracture consists of a simple linear crack of the skull, it will be necessary to make a trephine opening at one end of the fracture which will allow the entrance of a rongeur forceps to remove a strip of bone on each side of the fracture so that the underlying dura can be inspected and repaired if found torn.

Compound Fractures of the Frontal Fossa of the Skull generally open into one of the accessory nasal sinuses and show themselves by bleeding from the nose and mouth. The chief danger of such a fracture is meningitis. If the x-ray shows a fracture of the posterior wall of the frontal sinus, an osteo-cutaneous flap should be laid back exposing the interior of the frontal sinus and the site of the fracture in its posterior wall. This fracture should then be treated exactly as one would handle a compound fracture of the vault,

that is, remove the bone about the line of fracture and repair any dural defect.

In those fractures of the frontal fossa that cannot be so easily approached, Teachenor[4] recommends the establishment of drainage of the frontal sinus on the side of the fracture. The opening is made at the inner limit of the eyebrow and a tube inserted. His reason for this procedure is as follows: A patient with bleeding into the upper nasal cavities has an uncontrollable desire to blow the nose, and with each blow there is an increase in the pressure within the nasal sinuses which tends to force infected secretion and blood through the fracture and dural tear and thus produce a fatal meningitis. With the free opening into the frontal sinus, blowing of the nose will force the infected secretion through the drainage tube instead of into the subdural space.

I have never used this method, but it seems to me to be one of the most rational and valuable contributions to the treatment of this type of fracture that has been brought forth for some time. One of the most trying and disappointing experiences is to have a patient with a slight blow over the forehead followed by nose-bleed develop after a few days a fatal meningitis. From now on, until a better method is devised, all such patients coming under my care will receive a frontal fossa drainage. In most cases this operation is of minor nature; nevertheless I feel that it will be wise for the general surgeon to obtain the aid and co-operation of a rhinologist whenever possible to assist him in obtaining the best type of drainage.

Simple Depressed Fractures of the Vault of the Skull should be exposed in order to remove spicules of bone from the brain, to relieve local pressure, and to repair a defect in the dura. As the fragments of bone are clean they can be replaced over the repaired dura and thus serve as a bone graft. Failure to repair the defects caused by a depressed fracture may result in persistent headache, localized paralysis, Jacksonian epilepsy, and the formation of dural or brain cysts.

Operation to Relieve Compression of the Brain: Compression of the brain, as shown by a gradually increasing medullary embarrassment, may be due to the following conditions: extreme uncontrollable cerebral oedema; cerebral laceration with severe subdural hemorrhage, and extradural hemorrhage.

In the case of extradural hemorrhage with a lucid interval it may be impossible to differentiate and it is a fairly simple procedure to perform a subtemporal decompression, control the bleeding meningeal artery, and close the wound without drainage.

In cases of extradural hemorrhage *without* a lucid interval it may be impossible to differentiate the condition from a subdural hemorrhage or severe oedema. In either case, a subtemporal decompression is generally indicated. Before resorting to this operation, however, it is often well to do a lumbar puncture.

The subject of lumbar puncture in head injuries is one on which there is some difference of opinion. Some surgeons believe that a lumbar puncture should be done in every case of head injury. Sachs[5] states positively that a lumbar puncture should never be done in cases of head injury. But there are quite a few who take a middle course, performing a puncture according to certain indications. In the majority of cases I believe a lumbar puncture will not make any difference one way or another. It is true that a lumbar puncture will differentiate between a pure cerebral concussion and a cerebral contusion or laceration, as in the former condition the spinal fluid will be clear, while in the latter condition it will be bloody. However, this differentiation is of little if any practical value in treating the case. Moreover, the removal of the fluid is of no value in cerebral oedema, as the excess of fluid is in the substance of the brain rather than in the subdural space. In such cases the spinal fluid pressure is little if any above the normal. Sachs objects to lumbar puncture on the ground that in cases of increased intracranial pressure, when the spinal fluid is removed the force from above may push the medulla against the anterior rim of the foramen magnum, causing a respiratory failure and sudden death. He has experienced several such accidents and feels that the puncture is not only useless but very dangerous.

I have done lumbar puncture in head injuries for many years and have concluded that it is an absolutely useless procedure except in one condition; that is, in a patient in which we suspect a cerebral compression due to an excessive subdural hemorrhage secondary to a cortical laceration. Such a case may require a sub-temporal decompression, but before resorting to this operation an attempt to remove the excessive blood by the lumbar route should be tried.

As mentioned above, cerebral compression sufficient to require operation is generally due to an extradural hemorrhage. In such a condition a lumbar puncture is useless and a sub-temporal decompression is indicated as soon as the diagnosis is made. In those cases in which there is no lucid interval it may be difficult to differentiate an extradural hemorrhage from an extreme degree of cerebral oedema, or an excessive subdural hemorrhage. When we are confronted with an increasing intracranial pressure and are unable to differentiate between these three conditions, I believe a lumbar puncture, carefully performed, to be of value. Great care should be used to allow the fluid to escape slowly, drop by drop, to prevent compression of the medulla. If the fluid is clear it indicates that we are dealing with either an oedema or an extradural hemorrhage, and a sub-temporal decompression should be done

at once. If the spinal fluid is bloody it indicates that there is hemorrhage from a cortical laceration, and by withdrawing this blood from the spinal subdural space the results may be the same as from a cranial decompression. In a few such cases I have seen marked improvement following lumbar drainage, and the patient has escaped the major operation. If, on the other hand, this fails to relieve the cerebral compression, a decompression operation is indicated to remove clots and to establish drainage. Some advocate opening the skull over the area of injured brain when this area can be localized, removing the clots and placing a small rubber tissue drain through the dura to the contused area. This to me seems to be a dangerous procedure, as one is likely to traumatize the already injured cortex of the brain, and moreover, after removing the drain if the dura fails to promptly heal there is the possibility of the occurrence of either meningitis or cerebral fungus.

In cases of subdural hemorrhage from cortical laceration the method of choice is a sub-temporal decompression regardless of the site of the brain laceration. By this route more of the clots can be removed as the blood tends to settle in the temporal fossa. A small rubber tissue drain can be placed through the dura to the floor of the temporal fossa, to be removed in from twelve to twenty-four hours. However, it is very essential to place sutures in both the temporal muscle and its fascia and also through the skin at the site of the drainage opening. These sutures are left untied until the drain is removed, after which they are tied, closing the defect by a firm layer of muscle, fascia, and skin.

SUMMARY

In all cases of head and brain injury do as little as possible until shock has subsided.

The great majority of brain injuries, if they have a chance for recovery, will get well by the intravenous administration of 50 per cent glucose solution.

Only a small percentage of head injuries require surgery aside from the repair of scalp wounds.

The chief indications for surgery are compound fracture of the vault and frontal fossae of the skull, depressed simple fracture of the vault, and decompression for increased intracranial pressure.

Decompression operations for head injuries are performed more frequently than actually needed. Such an operation is always indicated in cases of extradural hemorrhage, but this is a comparatively rare condition. Decompression for subdural hemorrhage is rarely indicated and should only be performed when the signs of intracranial pressure are definitely increasing.

There is no claim for originality in this paper. It is simply a summary of the experience of those treating a large number of head and brain injuries whose results have been published during the past few years.

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HAY FEVER

THE EVOLUTION OF MODERN THERAPEUTIC CONCEPTS

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A nuisance serious enough to render about one per cent of the entire United States population suddenly miserable can hardly be ignored or laughed off—despite the annual efforts of some professional humorists in that direction. The characteristic watering eyes and running, itchy nose only too often completely incapacitate the hay fever victim for the pursuit of his work. And there is an even more disagreeable side to the matter: sound statistical evidence indicates that over half of all hay fever sufferers eventually develop asthmatic attacks.

Seventeen years ago Mr. L. Noon described a general method of treating the English type of hay fever. It involved the use of extracts made from the pollens known to be responsible for the disease. Noon died shortly after the publication of this significant work, but Freeman quickly amplified it and Clowes and Koessler promptly evolved similar tentative methods for treating hay fever in the United States.

Unfortunately the less critical among the medical profession received the news with such unguarded enthusiasm that many hay fever subjects were immediately assured that their days of suffering were at an end. Pollen injections enjoyed a season or two of widespread popularity—before the many complicated factors determining their preparation and administration were even beginning to be understood. The small percentage of patients actually cured occasioned bitter disappointment. Numerous physicians have even yet scarcely recovered from the skepticism engendered by that experience, and there are now in the United States undoubtedly millions of hay fever sufferers who are not enjoying the benefits of the last ten years' rich legacy of facts ascertained because of the prejudice born of their unfortunate experiences with pollen injections when first advocated.

The purpose of this paper is to state (as briefly and untechnically as possible) the present sta-

tus of the hay fever problem, to cite certain facts which have an historic bearing on the evolution of present conceptions, and to indicate what direction present trends in research seem to be taking.

Though referred to by Botallus of Pavia as early as 1565 and again by Beningerus about a century later, the disease was first adequately described by Bostock who in 1819 recorded the details of his own case. Heat and strong light, to which he attributed great causal importance, are now known to influence the course of symptoms only in so far as they mobilize pollen. The first really significant experiments with pollen were performed by Charles Harrison Blackley, a practitioner of Old Trafford, Manchester, who for twenty-five years had been himself a hay fever sufferer. He is generally credited with first having conclusively proved (1873) the English type of hay fever to be due to the inhalation of meadow grass pollens. By exposing at various altitudes a small varnished black metal surface, filmed with a glycerin-alcohol mixture, he accumulated a surprising amount of information concerning the variations in pollen content of the atmosphere. Furthermore, he showed conclusively that a definite relationship exists between the amount of pollen in the air and the incidence and severity of hay fever attacks. Finally, he demonstrated that the pollen of a common grass causing his own hay fever (Lolium Italicum), when moistened and applied to a scratch on his forearm, would produce there an irregular itching hive. This is the first record of skin testing, the technical procedure which perhaps more than any other has been responsible for the subsequent increase in knowledge of the specific causes and successful treatment of the disease. Almost coincident with Blackley's work Morrill Wyman showed flowering wormwood to be a cause of autumnal catarrh in the New England states. Thus as early as 1870 it was clearly recognized that the pollination season of certain relatively common grasses and weeds determines the incidence of hay fever in both England and the United States.*

Why should pollen grains (which average scarcely 0.000394 to 0.000788 of an inch in diameter) produce the sneezing, lacrimation, and nasal itching of hay fever when they encounter the nasal membrane of a sensitive individual? Some varieties of pollen grains (e. g. dwarf ragweed) have granular surfaces, which would suggest the possibility of purely mechanical irritation as the essential effect. However, if ground up pollen grains are extracted in suitable liquids, the resulting solution, even when freed of all debris by filtration through porcelain, will produce symptoms when instilled into the nose or eye of a pollen-sensitive individual, and the hypodermic injection of such a solution in suitable dosage will lead to a typical attack of hay fever. Thus pollen action on the nasal membrane is chemical as well as mechanical. That the active substance enters the general circulation producing altered reactivity throughout the body is indicated by the previously mentioned ability of the skin to react characteristically to the sensitizing pollen.

Though pollen is known to be only one of many substances capable of sensitizing certain individuals, little is known as to just why some people manifest sensitivity and others do not. That heredity had something to do with the matter was recognized fifty-six years ago, but it was not until 1916 that Cooke and Vander Veer showed that the tendency to become sensitized is transmitted according to the Mendelian law as a dominant characteristic. It is the tendency—not the specific sensitivity—that is inherited: a father who is sensitized to rag-weed may have a son whose hay fever is produced only by ipecac or guinea pig hair. Several European investigators have apparently found that certain diseases render people without hereditary predisposition liable to become sensitized, but the data on which their conclusions rest are still too meagre for generalization. On the other hand, healthy individuals with no hereditary predisposition seem able to encounter overwhelming amounts of pollen without becoming sensitized. (Among fifty pollen collectors, Coca observed, there was not a single case of sensitization.)

If the serum protein of a horse's blood be injected under the skin of a guinea pig and a week or two be allowed to elapse, a second injection of even a drop (0.1 cc.) of the same horse serum (especially if introduced into a vein) will almost certainly lead to collapse and death: the pig has become "sensitized" to the particular horse serum used. However, if in place of a drop of serum, 0.01 of a drop be given as the second injection, the pig remains unaffected; and at subsequent intervals one-tenth, one-half, an entire drop, even much larger amounts, can be injected with impunity. By this sort of procedure the guinea pig becomes "desensitized" (Besredka's method) as the body by highly complicated biochemical changes gradually acquires the ability to render innocuous the foreign substance introduced into its circulation.

Professor Dunbar of Hamburg, having in 1903 demonstrated that the toxic agent in pollen was protein, suggested the feasibility of vaccination against hay fever, and in 1911 Noon postulated a routine of treatment in which desensitization was to be effected by graded injections of the sensitizing substance—a process superficially resembling though not strictly analogous to the procedure in the guinea-pig-horse-serum case mentioned. Noon gave as his first injection five

*The fact that a few hay fever cases are purely psychic in origin was noticed about the same time by Professor P. Phoebus, who described a patient who had a hay fever attack "whilst looking at a beautiful picture of a hay field."

drops of the dilution of pollen toxin which produced redness and irritation when dropped into the eye of the individual to be treated. Others have since found the skin test a more convenient means of determining not only the specific nature of sensitivity, but its degree. Minimal amounts of the suspected pollen solutions are either introduced *into* the skin (by hypodermic needle) or applied directly to a superficial scratch. With recent developments in the technique of treatment skin testing still remains a most essential part of the clinical study of hay fever. While a patient's general history may clearly suggest the offending pollen, recourse to cutaneous reaction is the most convenient means of direct confirmation. Many workers still use the scratch method of Blackley (as modified by Schloss, Walker, etc.) Some prefer injecting a minute quantity of the pollen solution intradermally. The latter method is the more sensitive. The usual positive reaction in either case is the appearance in ten to twenty minutes of an irregularly outlined hive with a circumferential area of redness and itching.

Intelligent use of the skin test in determining the cause of hay fever symptoms requires not only familiarity with technique, but also a knowledge of what pollens may be present in the environment of the sufferer. In other words, one must study not only the patient, but also the air he breathes. Koessler in 1914 stated the general proposition that summer hay fever cases are due to the grasses (gramineae), the autumnal cases to the members of the sunflower family (compositae). The accuracy of this statement, as far as the United States is concerned, will be appreciated when one recalls that timothy and orchard grass, for example, occur in every section of the country except certain southern states, New Mexico, Nevada, Idaho and Montana; and short rag-weed in practically every state except Nevada and California. Unfortunately, however, there are other air-borne pollens of less general but quite as great local importance in their respective districts. While rag-weed is a native of Washington—both the city and the state—the Spokane citizen strongly sensitive to Russian thistle or sage brush (common weeds of the Inland Empire) is no more likely to get relief from rag-weed injections than the plantain-sensitive resident of the District of Columbia.

Some idea of the problem's complexity can be gained from the variety of weeds described as clinically important by various reliable workers in different sections of the country. On the Central Atlantic seaboard five grasses and plantain produce late spring and summer hay fever (G. T. Brown), and rag-weed is the main autumn offender. In the Texas district careless-weed is an additional factor of importance, and the grasses may operate in autumn as well as summer to cause hay fever—in fact, up until the killing frosts of the middle of January (Kahn). In the northwest district there is a tree pollen season (March-April), a grass season (May-June), and a Russian thistle-sagebrush poverty weed season (July-August). From 1924 to 1927 Piness studied over 350 varieties of wind-borne pollen collected on oil-covered microscopic slides exposed to California air. His report defines structural features of the pollen grains by which they may be identified. Studies of this sort are rapidly bringing within the ken of the alert physician the information necessary to make an intelligent choice of pollens for skin testing his patients. Perhaps even more encouraging is the tendency on the part of forward-looking commercial pharmaceutical laboratories to meet the problem in the true spirit of science by aiding less fortunate general practitioners who are too busy to make botanical surveys of their localities. A microscopic slide covered with a thin film of soft petroleum jelly, exposed for twenty-four hours in a window ledge at the hay fever sufferer's home, and mailed with due protection to one such laboratory will receive without expense the attention of its pollen experts.

It is possible that pollen sensitivity may not be as highly specific a phenomenon as is generally believed. Bermuda and Johnson grasses predominate in Texas, yet desensitization with timothy (not even a native of the state) yields protection not only against these native grasses but careless-weed as well, and rag-weed—which is botanically quite unrelated (Kahn). In the far West timothy desensitization has also been observed to confer general grass immunity (Scheppegrell).

Some investigators have gone so far as to treat hay fever by injecting protein substances in no way related to pollen, for example, milk, peptone, even crotalin (a protein in snake venom). Favorable results with various of these proteins have been recorded by reliable investigators. However, the technique of such procedures is still too imperfectly understood to warrant their discussion here.

Besides more general appreciation of the importance of accurate causal diagnosis, there are two factors which principally explain the transformation of the original hay fever therapy during the last seventeen years from comparative failure to almost complete success. They are (a) increased knowledge of what constitutes optimal treatment solutions and (b) better understanding of how to administer them.

The variety of methods used during the last fifteen years in preparing treatment extracts from pollens is in itself enough to occasion skepticism, unless one bears in mind the fact that the whole matter involves the question of protein biochemistry, one of the most highly complicated and as yet most imperfectly understood fields of modern science. Noon's original method of obtaining a protein solution was alternately to

freeze and thaw pollen in distilled water. Subsequently distilled water, various concentrations of salt water (with or without alcohol), and mixtures of salt and soda water (with or without glycerin), have been advocated as ideal media for protein extraction, residue and bacterial contamination being removed by filtration through porcelain.

Solutions of pollen as originally prepared in distilled or salt water and alcohol, were discovered to lose in a few weeks their ability to give a positive skin reaction—that is, their "potency." This loss of strength undoubtedly accounts for a large number of the original failures in hay fever treatment. Consequently Clock's addition of glycerin to the mixtures (which lengthened their period of potency to approximately a year) was a profoundly important step forward. Coca found that the addition of sodium bicarbonate in certain concentration had a similar effect. Subsequently the solutions of Clock and Coca have been rendered less irritating and more effective by varying the amounts of their several constituents (Bernton, Stier, etc.).

Though the technique of preparing stable and active treatment solutions is thus now well understood, a surprising ignorance still prevails as to the actual chemistry of the potent agents in the solutions. Most physicians lack training to study so technical a subject, and chemists are reluctant to attack a problem which inevitably leads into a field of clinical medicine where dangerous pitfalls await the unwary. For example, though Heyl succeeded in isolating three important proteins from short rag-weed, the injection of 0.000007 of a gram of one of these (the albumin) necessitated the removal of the treated individual to a hospital. Heyl concludes—a bit wistfully, one imagines—that the proteins had better be tested out by "some large hay fever clinic." Although it has been known since Kamman's work twenty-four years ago that rye hay fever, the common form in Germany, was due to a toxic pollen albumin, it is only recently that significant chemical studies (Caulfield, Bernton, etc.) of the American grasses and rag-weed have been made. Bernton observed that timothy contains two types of proteose and an albumin, and that most timothy victims are sensitive to several or all of these and relieved by treatment with a simple extract of the whole grain. However, those few patients who are sensitive *only* to the albumin, though deriving no benefit from treatment with the unfractionated pollen extract, are cured by injections of the albumin solution.

Despite these significant beginnings, present knowledge of pollen chemistry is still so uncertain that several competent investigators in the field question whether the active principle in pollen extracts is a protein at all—largely because of the facts that digestion with trypsin (the protein-splitting enzyme) followed by dialysis does not remove the active principle from rag-weed pollen, and that over half of the nitrogen present in pollen extract is in substances not immunologically important. However, Julia Parker demonstrated that large doses of pollen given to a female guinea pig so affect the uterus that the excised organ is sensitive to pollen solutions—a type of reaction generally attributed only to proteins. Furthermore, as Heyl has emphasized, qualitative tests for protein are at best misleading. Only when the active principle is isolated and its molecular weight determined can the question be finally answered.

One may well wonder why work continues on such a complicated problem as the chemical constitution of pollen when whole pollen extracts are known to be effective in so large a number of cases. The answer is probably threefold; man is by nature curious; a minimum of hay fever sufferers (for example, Bernton's albumin-sensitive timothy patients) must be treated with the simple protein to get relief; and finally, commercial synthesis of the active substances in pollen must await an exact determination of their chemical structure.

How must pollen solutions be administered to produce their effect? A hay fever subject sufficiently immunized to enjoy freedom from symptoms during the dissemination season of the pollen that troubles him must have acquired the ability to tolerate relatively concentrated solutions of that pollen injected under his skin—doses such as six to eight drops of a 1 per cent solution (by weight) of the pollen. The injection of such an amount to a previously untreated pollen-sensitive individual would almost certainly lead to disastrous if not fatal results. Such doses are given only after many preliminary injections of gradually increasing strength, and grave accidents in treatment can be avoided only by most careful attention to dosage.

Degree of sensitivity and development of tolerance determine the size of the initial injection and the rate of increase. Most men standardize solution strengths either by weight of pollen or nitrogen content of the solution: For example, Walker's 1-100 solution is actually a 1 per cent solution of the whole pollen. From known strengths dilutions are made according to the decimal system. It is the usual practice to inject as the first dose two or three drops of that dilution just too weak to produce a positive skin reaction. According to Walker's method, an individual showing positive skin reaction with all dilutions up to and including 1-10000, would receive three drops (0.2 cc.) of a 1-20000 solution as his first dose. Subsequent doses are increased as rapidly as is found consistent with safety. Anything resembling a hay fever attack shortly following treatment, or itchy red skin swelling at the site of injection, calls for a repetition of the same dose until it produces no such effect. From

these facts it will be at once apparent that no set treatment with a standard number of injections can possibly be optimal for every case. The acquisition of tolerance for maximal doses—that is, clinical immunity—may require anywhere from ten to fifty injections, depending entirely on the degree of sensitivity and individual responsiveness.

In view of these factors the importance of the time element in treatment will be obvious. Early experimenters with the technique of treatment preferred to space the injections five to seven days apart, making the process of desensitization cover the eight to ten weeks prior to the date of pollination. Many still favor this interval. Duke in 1925 profoundly altered and greatly improved the technique of treatment by shortening the interim between injections to a few hours, giving as many as two or three injections in a single day. Thus it is now possible to crowd the entire process of desensitization into a few days immediately preceding the hay fever season.

One of the first questions usually asked by a prospective candidate for desensitization is regarding the permanence of the immunity conferred. Until very recently the answer has had to be far from satisfactory; for it has long been recognized that such treatment would rarely protect for longer than the four to six weeks immediately following the last injection (the usual duration of the rag-weed season). Hence a necessity for becoming reconciled to the annual repetition of the desensitization nuisance.

Nevertheless there are encouraging signs that this may not always be necessary. Numerous investigators have observed some tendency in annually treated patients toward the ultimate development of a permanent immunity. In 1920 Vander Veer and Cooke began experimenting with monthly repetitions of the maximal dose attained in preseasonal desensitization. Quite recently they, and Aaron Brown, have reported cases in which immunity has been maintained several years with such a procedure. It is only fair to say that workers in other parts of the country (e. g., Kahn in Texas) have found fortnightly or weekly injections necessary to maintain constant immunity. The perfection of a perennial schedule for treatment requiring injections no oftener than every three or four weeks, would tremendously simplify the hay fever problem for both patient and physician.

As far back as 1873 Blackley observed various cases of hay fever apparently due to the "odor given off by certain animals." Fully convinced of the role of grasses in causing the disease, he pointed out the frequency of pollen in dry hay, the tendency of animals to get into hay, and the likelihood that their fur acted merely as a vehicle for pollen. It is now generally known that epidermal substances associated with goose and chicken feathers, wool, hair (dog, cat, horse, rabbit, guinea pig, etc.) may act precisely as pollen to produce the symptoms of hay fever. The attacks of sneezing may be clearly enough related to the source of trouble to enable the victim to make his own diagnosis and successfully treat himself by avoiding the cause. The horse dander sensitive patient usually knows enough to avoid horses, and feather patients frequently are enough impressed by the nocturnal character of their attacks to replace feather with floss pillows. However, the problem is not always so simple. Many patients sensitive to animal epidermal substances give an irregularly perennial history of attacks which throws absolutely no light on the possible cause. This discouraging situation is largely due to the clever disguising of many animal hair products that is practiced in various industries. The case of rabbit hair may be cited as typical. Rabbit hair sensitive individuals will insist that there is no possibility of their daily routine bringing them near rabbits, but unfortunately, rabbit hair is very commonly used in the upholstery of cheap furniture and for matting together the wool and cotton in felt hats. Furthermore, rabbit hair variously treated is commonly sold as ermine, chinchilla, seal, sable, and muskrat (Feinberg). As in the case of pollens, the final proof of specificity rests with the skin test. If the source of trouble cannot be removed or avoided, desensitization similar to that with pollen is the procedure of choice.

Many people afflicted with perennial hay fever owe their trouble to orris root—a sweet scented substance derived from the root stalk of the Florentine iris and commonly used in the manufacture of face and bath powders, soaps, packs, cosmetic creams, and tooth paste. Orris root hay fever occurs the year 'round and sensitive individuals are most likely to suffer attacks when among indoor crowds (theatres, night clubs, etc.). Balyeat advises his patients to use no face or body powders, bath salts, sachets, nor scented soaps, but over three-fourths of them are so highly reactive that desensitization is necessary. This, again, is effected according to a plan similar in general to that used with pollen.

Seven years ago Kern—and more recently Rowe (1927)—emphasized the importance of another much less common sensitizer which may cause perennial hay-fever—some unidentified substance in house dust, often the dust of a particular room. Opinions differ as to whether the agent is one as yet undescribed or merely a mixture of known animal danders. However, it is clear that irritation in these cases is not merely mechanical for skin tests with the particular dust are positive and desensitization is effective.

While this small group of non-seasonal hay fevers presents features of great scientific interest, it is clear that pollen sensitization, because no doubt of its much greater frequency, will continue to monopolize the attention of research

workers. Despite refinements in the technique of treatment, one feature which will always be objectionable remains—the hypodermic needle. Since Dunbar had shown in 1903 that the toxic substance in pollen was protein, the introduction of pollen solution hypodermically instead of by mouth was doubtless first instituted so the protein might enter the general circulation unchanged by digestive juices, and thus stimulate directly the production of protective substances in the blood. Quite recently Matthew Walzer has ingeniously shown many proteins to be absorbed unchanged from the intestinal tract directly into the circulation. This surprising fact at once raises the question of whether pollen protein can be so absorbed. Unquestionably the matter will be thoroughly investigated in the next few months. As far as I know, J. H. Black alone has thus far published experiments in this connection. Himself highly sensitive to giant rag-weed, he took three times a day, by mouth, over a period of a week, a total of approximately one ounce of a giant rag-weed solution, the individual doses ranging from a drop and a half to almost half a teaspoonful. Though before treatment a drop and a half of 1-10000 solution of rag-weed extract produced regularly, when dropped into his nose, paroxysms of sneezing, it required eight times this amount to produce the same reaction after a week of the extract by mouth. At least partial absorption of the ingested pollen was proved by its presence in the blood and urine. Black claims subsequently to have used a similar method with "most gratifying results" in the treatment of one hundred and fifty cases of pollen asthma and hay fever during the rag-weed season. Thus it seems reasonable to hope that even the hypodermic injection may eventually be eliminated from the technique of pollen desensitization.

Another possible trend for future research may be in the direction of an attack upon pollen as it occurs in the air. Van Leeuwen in Holland has already secured for his patients (in 1926) a pollen-free atmosphere by enclosing them in hermetically sealed rooms ventilated by motor driven fans which filter incoming air through cotton. More recently Cohen of Cleveland has perfected a mechanical filter suitable for window attachment. Since its air intake is approximately 200 cubic feet per minute, stale, pollen-containing air is rapidly displaced from the room through the inside openings and a pollen-free atmosphere secured. The filter, which is of specially woven cotton and wool, is 99 per cent efficient for test solutions of pollen grains (0.000394 to 0.000788 of an inch in diameter) and 62 per cent efficient for even the particles (0.000010719 of an inch in diameter) that constitute tobacco smoke. According to Cohen, twenty-four to thirty-six hours of breathing pollen-free air leads, in the absence of complications, to relief for the average hay fever patient, and thereafter he may remain symptom free by staying in the pollen-free atmosphere several hours each day.

Enthusiasts have advocated state- or nation-wide weed cutting campaigns with the hope of completely eliminating hay fever pollens. On clear sunny days pollen is plentiful in the air at 4,000 or even 6,000 feet and frequently rises to a height of 15,000 feet (aeroplane observations); and even during periods of calm it is known to have traveled many miles in settling. Furthermore, Blackley, himself, pointed out over a half century ago that practically infinitesimal amounts of pollen are necessary to produce the disease. In view of these facts and the well known hardihood of most hay fever weeds, it is hard to view the problem of outdoor air depollinization optimistically.

However, when one recalls that though hay fever has been recognized as a clinical entity over three hundred and fifty years, our knowledge of its therapeutics first began to be developed scarcely seventeen years ago, it is reasonable to hope that the next decade may solve most of the practical problems that still remain.

OSTEOMA OF FRONTAL SINUS

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Osteomata of the frontal sinus are composed of true bone and characterized by a hard ivory-like surface. The most important predisposing factor in relation to the sinuses is widely held to be a congenital fault, or an anomaly of growth. This congenital, or growth anomaly (cartilaginous rest, osteophytes, etc.) may be activated, possibly, by some such factor as trauma, or chronic inflammation. Trauma as the exciting cause was the first theory held and is yet believed by many. In a number of instances a very severe blow on the head has preceded the appearance of the tumor. Thomas reports a boy in whom an osteoma of the left frontal sinus appeared one month following a severe blow in that region, by a baseball. The exact relation of trauma to these growths is problematical. Chronic sinusitis is also mentioned frequently as an exciting factor. Huchlenbroich stated that 37.5 per cent of these sinus tumors were accompanied by sinusitis. Though an inflammation may exist it does not follow that an infection is present. Sewall reports that the lining of the sinus, in his case, was engorged and thickened, and that some fluid was present containing shining particles resembling cholesterin. There was no sign of infection. Chapman reports the cavity of the sinus, after removal of the tumor, was lined with a greyish glistening membrane, and the portion of the sinus cavity not occupied with the tumor filled with a milky-white mucus appearing fluid. In the author's case there was no sign of inflammation or infection. Constitutional maladies, particularly syphilis, have

been associated with these sinus tumors, but while syphilis is responsible for many conditions, it is difficult to conceive of syphilis being a factor in the origin or growth of tumors of this character.

In the human these tumors vary from the size of a bean (.7 gms.) to that of a baseball (440 gms.), tumors of both sizes being reported. They may have a single or multiple attachment. Probart reports a tumor attached to the inner wall of the sinus by a broad pedicle. The author's case had no demonstrable attachment.

Histologically osteomata are true bone. They vary in hardness. It is characteristic of them to

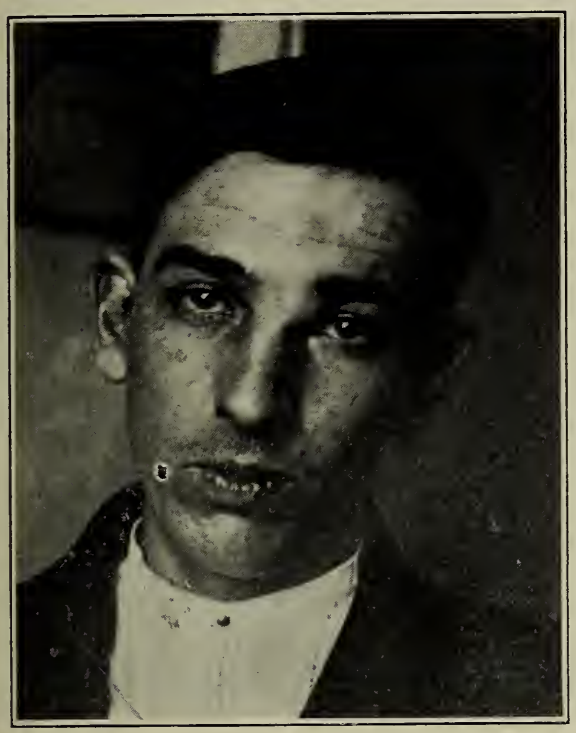


Figure I.

Note broadening effect at base of nose and projections at center of forehead.

have a hard, eburnated, ivory-like surface, although there may be parts of the tumor distinctly cancellous.

Absence of subjective symptoms is quite common in the beginning. Many of these patients are unaware of the presence of the growth until some deformity of the frontal bone presents itself, or until the tumor reaches such size as to cause serious pressure on the eye, or within the cranial cavity. In Sewall's case, continued and persistent frontal and occipital headache was complained of. This headache was later localized above the left eye and increased in intensity and frequency. Associated with the headache was sometimes fever and a marked loss of weight, (thirty-five pounds in six months.) The symptoms in this case are unusual and not at all typical of the condition. Objective symptoms arise from the growth of the tumor. Ptosis may be noted, followed by displacement of the eyeball. In the case of a tumor of the frontal sinus, the eyeball is pushed downward, outward and forward (Gerber's classification). As the tumor forces itself through the sinus walls, bony protuberances appear on the frontal plate and near the inner canthus of the eye, especially if the growth occurs toward the front as it most commonly does. Occasionally the growth takes a posterior direction into the brain. It is these bony outgrowths about the orbit which frequently call the patient's attention to the tumor.

The x-ray shows an abnormal shadow in the region of the sinus, usually with enlargement of the sinus itself. The pressure absorption of the walls of the sinus is sometimes shown, giving a clear demarcation between the tumor and surrounding tissues. In this connection, let us emphasize the importance of x-ray study in the presence of obscure symptoms about the orbit.

The diagnosis is relatively easy if a deformity is present, such as shown in Figure 1. In the absence of deformity, the x-ray is the main differentiating factor between this and other conditions of the sinus. The clear line of demarcation between the tumor and the sinus walls sometimes seen on the skiagram is pathognomonic.

Case Report. A young man, age twenty-seven, presented himself because of a growth near the inner canthus of the left eye. He had been unaware of this condition until it was called to his attention by a companion about a year previously. The growth had progressively increased in size, until there was some obstruction of vision when looking toward the right. Since the discovery of the original tumor, a second growth had appeared near the center of the forehead. There was no pain, or symptom beyond the slight interference with vision above referred to. There was no history of veneral infection. The patient had measles when a child, and diphtheria and appendicitis when a young man. Otherwise he had been well. His family history was negative. On examination the deformity was evident. The inner angle of the orbit was filled with a hard mass, not tender to touch, and over which the skin was movable. The effect was of a broadening at the base of the nose. (See Figure 1). There were two smaller projections of the tumor on the forehead, the larger of these two projections being at almost the exact center, the smaller close to it and to the left. Wassermann was negative. Nasal and eye examinations were negative. General physical examination revealed nothing of importance. The x-ray revealed a very dense shadow in the region of the left frontal sinus. The area of the sinus was much enlarged. There was no clear line of demarcation between the tumor and the sinus wall.

An incision was first made in the center of the forehead over the projections of the tumor in that region. It was found that these projections

had penetrated the frontal bone and were beneath the skin. The frontal bone was chipped carefully about these projections, until landmarks were established, and it was then possible to remove a large part of the anterior plate of the sinus which was paper-like in thickness; the supra-orbital ridge being preserved. The osteoma was seen to fit the sinus cavity, which was much expanded, as a kernel would fill the shell of a nut. The posterior wall of the sinus was intact. A second short incision was made at the inner angle of the left orbit, and by means of a chisel, cutting above the supra-orbital ridge, this projection was separated from the main body of the tumor and removed from below. The neck of this projection was more cancellous and consequently more easily cut than the rest of the tumor whch was very hard. The main body of the tumor, however, was not uniform in consistency and was rather brittle, becoming fragmented in lifting it from its bed. There was no pedicle, or evidence of attachment of the tumor to surrounding bone. The size of the sinus was amazing, the cavity extending upward and to the right much beyond the usual limits. The extension toward the outer angle of the orbit was not so noticeable. There was no fluid in the sinus cavity, nor was there any evidence of infection or inflammation.

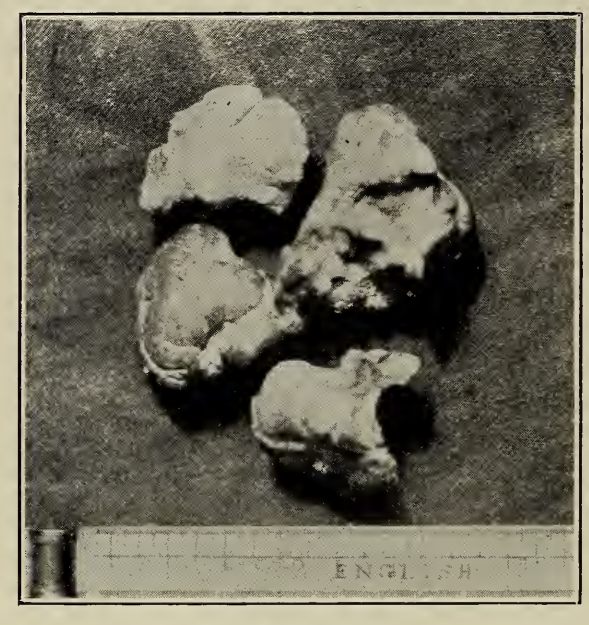


Figure II.
Fragments of osteoma. Actual size.

Closure was made without drainage. Healing was by first intention. Recovery was uneventful. Beyond some flattening in the left frontal region above the supra-orbital ridge the cosmetic result was excellent.

Comment. Osteomata of the frontal sinus are hard bony tumors whose mode of origin is obscure. The most widely believed theory of their origin is that of a developmental anomaly. They are essentially benign but malignant in effect. They sometimes recur after removal. In this respect only do they resemble malignant growths. Histologically they are true bone. Symptoms arise only from the pressure and deformity they produce by their growth. Treatment is confined to their complete surgical removal.

BLOOD TRANSFUSION IN DIARRHEA

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During the late spring and early summer of 1927 there was an epidemic of atypical infectious diarrhea occurring in Western Kentucky, with a certain number of cases on the Indiana side of the Ohio river. The symptoms and clinical findings were not those of typical infectious or bacillary diarrhea. There was little or no tenesmus. The blood and mucus in the stools often appeared on the first day of illness, usually disappearing from the stool in the course of three to four days at which time the stools became watery, green, acid and fermenting—typical stools of fermentative diarrhea. Most of these cases came from farm houses or villages in which the water supply was obtained from wells. During the winter of 1926-1927 and the spring of 1927 the rain fall in the Ohio Valley was exceedingly heavy and it is possible that the percolation of the water through the subsoil into the wells carried with it pathogenic micro-organisms, possibly of the colon group, infecting the well water.

Blood transfusion for acute infections of children and for those suffering from dehydration as a result of infectious diarrhea has been found very beneficial in the hands of many physicians. We believe it to be a life saving agent in the most serious cases, as is illustrated in this case report. The transfusion of blood, when one is equipped with laboratory facilities for blood matching, is so simple that we feel that no child in this condition should be denied it and that physicians who are not in a position to transfuse these children, should not delay in sending them to the nearest possible point where blood transfusions may be obtained. If the transfusion is delayed too long, recovery becomes much less likely.

Feeding in this case was quite a liberal one, a diet high in protein with a gradual increase of carbohydrates from the earliest days of its stay in the hospital. The diet consisted of protein milk, fruit juices without the addition of sugar, dry toast, rusk and wheat cereal. Medicines, apart from some drug to alleviate restlessness, are so nearly worthless in this condition that we rarely prescribe them.

Case Report.. V. S. S., age three years, ten months. Referred by Dr. R. L. Moore, Marion, Kentucky. Patient entered the hospital on June 11, 1927, complaining of diarrhea, loss of weight and unconsciousness. The child had been ill

three and one-half weeks. Temperature 102.4. pulse 118.

Family History. Father is living and well. Mother died a few months ago, supposedly of tuberculosis. There are four other children in the family, living and well.

Past History. Child has never been severely ill.

Head: Eyes, ears, nose and throat, no history of an unusual number of colds or sore throat. Cardio-respiratory: No dyspnea or coughs. Gastro-intestinal: The child had a fair appetite up to the time of the present illness. There is no history of previous diarrhea or unusual constipation. Genito-urinary: Negative for any previous trouble.

Present Illness. Three and one-half weeks ago the patient had an elevation of temperature in the late afternoon. This was soon followed by a convulsion, vomiting and numerous loose stools. After the first three or four bowel movements blood and mucus appeared, which continued for four or five days. A rapid loss of weight took place and it was found practically impossible to feed the child. After the fourth or fifth day of illness, the stools became watery, green, acid in reaction, showing all of the characteristics of the stools of fermentative diarrhea. This continued up to the time the child entered the hospital.

Physical Examination. The child shows marked loss in weight, there is marked dehydration and the lips are dry and cracked; he is very restless, tossing his arms and rolling from one side of the bed to the other. The body odor is very offensive and reminds one of typhoid. The eyes are retracted; the remainder of the head is negative. *Chest.* The heart action is exceedingly rapid and, due to the loss of subcutaneous fat, it is almost impossible to tightly fit the stethoscope to the child's chest. Respiration is fast, comparatively deep, no rales. *Abdomen.* The abdomen is scaphoid, and has a doughy, putty feeling, but no glands are palpable. Reflexes are not exaggerated. The patient is comatose and vomits all food and fluids.

Luminal in one-half grain doses every six to eight hours was ordered to produce rest, check vomiting and diarrhea. It was discontinued after the fourth day.

Laboratory findings: Urine: Clear, acid albumin, 4 plus; sugar, 1 plus; hyaline and granular casts, 4 plus; epithelial cells, 1 plus; blood cells rare. Hemoglobin 70 per cent. White blood cells, 20,000. Red blood cells, 3,820,000. Polymorphonuclear, 85; large mononuclears, 1; small mononuclears, 14.

June 12, 1927. There is no improvement, and vomiting continues. The temperature was 102.2 at 6 P. M. yesterday and 103.2 at midnight. In the forenoon five hundred cubic centimeters of normal saline solution containing 50 grams of dextrose was given into the jugular vein. The child made absolutely no resistance. Following this urination was very free for several hours, and during the afternon and night fluids and foods were taken and retained much better. Patient is less restless but is still semicomatose.

June 13, 1927. Spinal puncture, pressure 4 m.m. Only a few drops of spinal fluid was obtained. Cell count 4, no globulin. At 4 P. M. temperature was 103.2 and at midnight 99. Radiographic examination of the chest was negative.

June 13, 1927. At 2 P. M. 230 cc. of whole blood was given by the direct method into the jugular vein. The child made no resistance. Within a few minutes after completing the transfusion, the child opened his eyes and looked about the room as if coming out from a prolonged sleep. The skin was pink and the heart action slightly increased; breathing was deeper and the child looked much improved. He was returned to the room and within a few minutes relapsed into a comatose condition with the appearance of approaching death. Later in the afternoon when visited he was found to be rapidly coming out of the comatose condition and at intervals looked about the room with wide open eyes for several minutes at a time. Child taking food with difficulty, but the improvement is striking.

June 14, 1927. White blood cells, 11,100: red blood cells, 5,020,000; polymorphonuclear, 69; large mononuclears, 3; small mononuclear, 28. The bowel movements were fewer in number and the odor was less pronounced. The abdomen is less scaphoid and the child shows improvement regardless of the difficulty in getting him to take food and fluids.

June 15, 1927. Considerable improvement shown over yesterday. Temperature remains about 99. Takes food much better.

June 19, 1927. Since last notation, child has made rapid improvement. Only four or five stools daily. Appetite is good. Skin is pink, circulation is full and improvement in his general conditon is remarkable.

June 27, 1927. Discharged from the hospital having only two bowel movements each 24 hours, fairly pasty and thick. Appetite good. Gain in weight of five pounds. Skin is pink, child is happy and insists a number of times each day that he be permitted to dress and play.

This case was selected as an example of the fairly severe to severe cases of continued diarrhea after infection has passed the acute stage, and to show the striking effect of blood transfusion.

SPECIAL ARTICLE

DECORATING THE PHYSICIAN'S OFFICE

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INDIANAPOLIS

An artistic office is part of a physician's stock in trade. It is as essential as a pleasant personality in attracting to him the class of patients he wants. In these days much stress is laid upon the importance of our physicial environment, and the effect of superior office surroundings upon the psychology of the individual can scarcely be overestimated. A need of personal comfort is the urge responsible for all calls upon the physician and his ministration to this need should begin from the moment the patient puts his foot over the threshold.

It is an interesting paradox that the American business and professional man who demands so much of luxury and comfort in his own home is generally neglectful of his office, and often he is content to have it furnished like a ware-house. His home, he believes, should express something of his feeling of warm cordiality toward his friends. He would not dream of receiving them in a barren room with a row of chairs around the wall, and last year's magazines on the table. Yet this is exactly the treatment that he often metes out to those who seek his professional aid. At home he requires soft-tinted walls, with pictures, and colorful hangings; but at the office he apparently is satisfied with shiny paint, a few framed certificates, or a picture of the graduating class, and undraped windows. His home boasts a luxurious upholstered divan, and comfortable chairs, but ten to one there is a bumpy leather sofa in his office, supplemented by typical clumsy "office" furniture. Now this is a state of affairs that could be remedied easily without the expenditure of a large amount of money. Good taste and a little thought would go a long way toward converting these expressionless offices into cheerful and homelike rooms. Certainly a man's office, as well as his home, should express something of his personality; it should tell something of his taste in art, his attitude toward life, and his feeling for his profession. A few pictures indicative of the interests of the owner, or a collection of objects representative of some cherished hobby, help to create a certain personal atmosphere exceedingly attractive to humanity whether it be sick or well.

Reception and consultation rooms should be devoid of any suggestion of the hospital. The familiar smell of iodoform which used to cling about the physician's office has almost disappeared. And with it should go all other appurtenances unpleasantly suggestive of illness. Whenever possible, it is best to have a small adjoining operating room or laboratory in which to keep instruments, medicines, and snow white apparatus. Apart from this, the office should be livable and restful, and exude the friendly intimacy and welcome of the home of a personal acquaintance. The consultation room, in particular, might well take on the appearance of a small private library, conducive to intimate and sympathetic conversations.

The following suggestions as to how to refurnish and decorate the physician's office so as to produce the desired personal atmosphere, are offered and may aid in transforming the offices of those interested at a comparatively small cost.

The first thing to be considered is the system of lighting. The electrical fixtures of many offices produce an unfortunate glare. Indirect lighting always should be used for general illumination, as it more nearly resembles the sunlight. A few well placed lamps for reading add to convenience and supply beauty.

If color is used on the walls, it should be toned down with a transparent glaze of amber or gray. This process not only softens the shade, but makes the surface more practical in that when it is so treated it will not show finger marks or other soil so readily. Glaze does for the walls what time would otherwise take months to do. It removes the glare from color and lends to it the mellow tint created by age. Such a neutral background would set off admirably an interesting picture, possibly by some local artist, or a printed tapestry panel of good design.

For the floor, which usually is a cold cement slab, a carpet is preferable. Although a plain color is always to be desired, the floor covering may have a small pattern frequently repeated. The green office drugget is obsolete, and the death knell of the taupe rug has been sounded. All the new rugs and carpets are warm and colorful. If color is used on the walls, then the rug should be beaver, or some shade of wood brown. But if the walls are neutral, then jade or one of the new egg-plant shades may be used on the floor to excellent advantage.

The most usuable type of curtains for the doctor's office are the double-decked, or dutch curtains, made of some substantial wash material. The advantage lies in the fact that the lower set can be drawn and the upper set separated to admit light and air. Two sets of these curtains should be made so that one may remain in place while the other is laundered. The best opportunity for the introduction of color into the room is offered by the overdrapes which always should be in pleasing contrast to the walls. There are some rayon damasks on the market now at moderate prices which in most cases are washable and color fast. These adapt themselves particularly well to this type of room because of their dignity, durability, and reasonable price. By all means avoid a combination of stripes and figures. If stripes are used, let them be multi-colored, but plain; whereas if figures are used, let them be two-toned, or of two soft blending colors. The

curtains should be simply hung from a pole. If rods only are available, a shallow valance should cover the rod and carry the color over the top.

In the selection of the furniture, leather should be avoided unless some of the very new, colorful leathers in soft greens, reds, or blues are used. The doctor should strive to get away from loose cushions, which so soon begin to look slovenly. Comfortable chairs, with tight seats, upholstered backs, and wood arms to withstand soil, are the most practical. Small occasional tables, and a piece of wall furniture, taller than the rest of the furnishings, will give the room a harmonious appearance, and prevent the effect of stiffness so deplorable in the usual office furniture. For the secretary's desk, there are many attractive models to be had in dark woods, with a tier of drawers on one side, and the other resembling the ordinary library table. The wall filing cabinets now turned out by the better furniture manufacturers are no longer made of golden oak, and "built like a sky-scraper," but are artistic and ornamental pieces, every bit as practical and no more expensive than the old ones.

By all means, either in the waiting or the consultation room, there should be a mirror for the convenience of the ladies, and the surreptitious use of gentlemen. A dressing table would be somewhat out of place, but an attractive mirror, simply hung over a small table, or a wall cabinet, would be appropriate. The public comb and brush should be omitted, though a bottle of toilet water, or a vase of flowers from the doctor's own garden would be refreshing. There should be nothing superfluous or confusing to detract from the general effect of harmony in the room. Simplicity and good taste are the allies of beauty, and are more telling in their effects than elaboration and expense.

In the consultation room, the doctor's desk should not be the ordinary roll top office desk. Here, again, he should use furniture of the type he would choose for his own library at home. His books should not have the "touch-me-not" look produced when they are displayed behind glass. An upholstered couch with small pillows instead of the usual hard leather or wicker lounge; a decorative screen to replace the burlap one; a few well-hung and simply framed pictures instead of the framed license to practice medicine. This is the ideal consultation room, and it is safe to say that such an atmosphere will serve to benefit the patient physically, mentally, and spiritually.

A few effective color combinations which have been worked out with considerable success are here suggested. For the floor, use an egg-plant carpet. Paint the walls and woodwork a soft new apple green. With this, use hangings of a full-toned gold color. The advantage of having the woodwork the same shade as the walls is that it is "painted out" and the objectional breaks in color are avoided. The woodwork, however, often can be successfully left a soft natural wood finish. Another scheme for producing an effect of much beauty can be worked out by doing the walls and woodwork in soft corn yellow, using with this a rug in a full jade tone of green, and hangings of the same general color. Hard, crude color always should be avoided, as tones that are soft, but full, are most harmonious.

Such an office is the best possible form of personal advertising. It expresses charm, hospitality, and friendliness, and bespeaks the doctor's position in the professional world. A patient received in surroundings of beauty and dignity will respond with a different outlook on life than he who walks into an ugly, ungracious environment. The office, then, is a vital factor in establishing a desirable relationship between physician and patient, and a moderate investment of effort and money will bring a lasting return in distinction and satisfaction.

EFFECT OF LIQUID PETROLATUM GIVEN BY MOUTH ON DIGESTION AND ABSORPTION OF FOOD

The effect of liquid petrolatum given by mouth on digestion and absorption of food is studied by Alfred B. Olsen, Battle Creek, Mich. (*Journal A. M. A.*, July 21, 1928). He made researches in dogs and in human beings and gives the results of his experiments. The author concludes that laboratory dogs with one meal a day have only one regular stool daily with an average motility of about eighteen hours. The feces of the dogs uniformly contained large quantities of hair, which may serve a useful purpose as roughage and may be useful in stimulating peristaltic activity of the bowels. The use of muzzles to prevent the eating of the hair not only worried the dogs but seemed to cause constipation. From the experiments on dogs it would seem that the use of liquid petrolatum given by mouth does not interfere with the digestion or absorption of protein food as judged by the fecal waste of nitrogen. While the students considered their bowel action normal before the experiment, the fact is that all of them had a varying degree of constipation. In most cases the oil encouraged better action and produced softer and more natural stools, although the effect was comparatively mild. The taking of 15 cc. of liquid petrolatum with meals three times a day did not appear to upset, hinder or in any other way interfere with the digestion and absorption of the food as judged by the nitrogen and carbohydrate waste eliminated by the stools, nor did it affect appetite. The amount of nitrogen waste as determined by fecal analysis was not increased when the students were taking liquid petrolatum with each meal, but remained practically the same. What is true of the nitrogenous waste holds also for the carbohydrate elimination. Analysis shows that the amount of reducing substance in the feces is not increased by the taking of liquid petrolautm. The results of both experiments, in dogs and in human beings, indicate that the taking of liquid petrolatum by mouth in therapeutic doses did not interfere with the digestion and absorption of protein and carbohydrate food.

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EDITORIALS

CERTIFIED MILK

At the 1927 session of the American Association of Medical Milk Commissions held in Washington, some interesting statistics were presented. It is well known that the dairy industry is an enormous industry, being the largest in the world and having more far-reaching effects upon the health and prosperity of this nation than any other industry. It is not generally known that during the last few years there has been a very large increase in the consumption of milk, or from forty-four gallons per person in 1920 to nearly fifty-four gallons per person during 1926. During the same length of time there has been an enormous increase in population, at the rate of two million more people each year. Naturally. the dairy industry must meet this demand and that means an increase of cows and better methods of production. The certified milk industry has arisen as a direct result of the demand of physicians who have asked for clean, wholesome milk, the best milk that can be produced. In other words, certified milk is the product that represents an effort to keep milk in the condition and of the quality that nature intended the milk to be. In nearly all of the large cities of the United States there are milk commissions composed of members of the regular medical profession that lay down rules and regulations under which dairies shall be conducted and milk produced and marketed. These milk commissions have insisted that the dairy products known to the public shall be of certain quality and reasonably free of impurities of every description.

For those wanting a grade of milk that is almost as nearly perfect as can be made by the time it reaches the consumer, a quality known as "certified milk" has been created through a system of rigid inspection of everything pertaining to the dairy industry, including care and health of cattle, feed given the cattle, sanitation of dairy, health and cleanliness of operatives, promptness with which the product is delivered to the consumer and the methods employed in so doing. In order to maintain a very high standard it has required an eternal vigilance in order to justify the certified milk grading, but a growing number of people are beginning to realize the value of such a product even though its expense is a trifle greater than the so-called pasteurized milk which many have claimed is merely a method of making safe for human consumption a milk that has been produced and handled under questionable conditions. As one medical member of a milk commission well says, "While pasteurization lessens certain minor dangers it enormously increases other and even greater evils." The impression generally prevails that it matters little whether the milk is clean or teeming with microorganisms providing only that it is pasteurized, and this confidence in pasteurization as a means by which unclean milk can be rendered as safe and wholesome as clean milk is unfortunate. Clean milk is just as important as clean water, and there is no method by which milk, once contaminated with stable filth, can be made perfectly safe for use for infants or adults without destroying some of its constituents which are essential to good nutrition. It is, of course, to be admitted that pasteurization is a most valuable means of protection against infection with typhoid fever, tuberculosis, and other milk-borne infections. Pasteurization does not protect against infection of the intestinal tract with the putrefactive organisms which because of their widespread action are, as a matter of fact, the cause of much more disease and many more deaths in infants than are the bacteria which give rise to typhoid and other infections.

In many localities there is room for a campaign of education, not alone among the people but among the members of the medical profession, to effect a general recognition of the fact that clean milk, produced from healthy cows by clean methods and showing a low bacterial count, undoubtedly is an economic saving, as it will prevent illness and doctor bills. Certified milk may cost a little more but it pays in the long run. On the other hand, it would be unfortunate if we overlooked the virtues of pasteurized milk, which, when all is said and done, probably will be the milk for the masses, for we must admit that as a result of pasteurization the public is getting a better milk than it ever had before. However, to the pediatrician and to the mother who wants her children to have the best milk, it may be interesting to note that whereas certified milk usually has a count well under ten thousand, not having been heated and nothing having been done to it except to keep it clean, it will be somewhat of a surprise to many to learn that pasteurized milk, even after pasteurization, has a count of forty to fifty thousand and sometimes more, and even then is considered very good. Even when certified milk has been pasteurized, as is sometimes indicated during epidemics, it will be found that pasteurized certified milk has a lower count than the regular pasteurized milk.

The whole problem of milk supply from the health standpoint is one of obtaining a safe supply, but from the physician's standpoint it also resolves itself into the question of securing the

best supply that can be obtained, and when regulation standards are followed, as they nearly always are when controlled by medical milk commissions, the certified milk comes nearest to being the ideal.

NEED FOR MORE GENERAL MEDICINE AND LESS SPECIALISM

Much has been said concerning the ill-timed study of the specialties and the neglect of the study of general medicine by undergraduates in medicine. Prominent men in the medical profession, including educators, officers and ex-presidents of the American Medical Association, and editorial writers have discussed the subject, and still we do nothing to correct a condition that is threatening to discredit medicine as a whole to a more or less extent. You cannot have a good specialist unless he has a good practical knowledge of general medicine, and yet many medical schools seem to think that such is not the case and they go on emphasizing the study of the specialties, and our boards of medical registration and examination continue to make the passing of an examination in the specialties a requirement for licensure. With such a policy in vogue we are turning out of our medical schools a lot of physicians who are not well balanced, and about ninety per cent of whom are rushing into the specialties without having had a very thorough grounding in the essentials of general medicine and with only a superficial knowledge of the specialties. It is true that some of these graduates take the proper view of the subject and continue their work by taking extensive postgraduae courses, sometimes running into two to five years, but there are altogether too many of the recent medical graduates who immediately start out as specialists and announce their intention of devoting their time exclusively to some specialty even though they have had but a limited and very superficial training in the specialty selected. As a direct result of this the medical profession is getting into bad repute, and the public is being deprived of a quality of service that cannot be given by men inadequately trained.

We have physicians posing as surgeons who scarcely know how to apply a hemostat, and who possess but a limited knowledge of the diagnosis and differentiation of the various surgical affections. Statistics show that in the past two decades there has been a steady increase in the mortality rate attending many of the common surgical procedures. The mortality rate attending goiter operations has increased two hundred fifty per cent; gallstones, seventy-seven per cent; duodenal and gastric ulcers seventy-two per cent, and appendicitis, thirty-one per cent. (Willis, address before American College of Surgeons.) A study of the death rate from appendicitis operations in Michigan (Carr and Deacon) shows that it varies from five per cent to twenty-one per cent or more. Compare these results with those of Quain and Waldschmidt (*Archives of Surgery*, April, 1928) who report a thousand consecutive appendicitis cases with a mortality of only 1.55 per cent, or Tuttle's (*Boston M. and S. J.*, June 2, 1927) summary of work in Panama covering a period of nearly twenty years and comprising three thousand two hundred sixty-five cases with a total mortality rate of one and four-tenths per cent. These two series, totaling well over four thousand cases, with an average mortality of less than one and five-tenths per cent, may be taken as representative of the legitimate mortality attending the better class of surgery. Contrast these results with the approximately fifteen percent in an average state as analyzed by Carr and Deacon. The difference of one thousand per cent between the average and the good is too great. An analysis of the situation shows the difference is due to the degrees of professional ability. The constantly increasing volume of indifferent surgery is without question responsbile for the rising mortality rate. The explanation is obvious. Where one practiced surgery twenty years ago, one hundred are endeavoring to do it now. In other words, the surgery of two decades ago was performed by comparatively few men. In spite of their lack of opportunity for study and observation, and the imperfections of hospitals and equipment, their results averaged better than those of today. These men were pioneers in this work, and kept a close record of their results. We fail to recognize the fact that the volume of surgery no longer is performed by a few men, but is practiced by a majority of doctors, and not even limited to doctors of medicine.

The weakness of our system of healing lies in the fact that we have provided no sufficient protection against the incompetent and careless. While the representatives of this class are chiefly to be found outside of the regular profession, the patient has too little means of determining this fact. The patient, whose life is at stake, should have an opportunity of knowing the doctor's actual experience, and the success that has attended his previous work. Many physicians of today are satisfied in the belief that if they have enough self-assurance they can get away with anything with their patients, and that at best surgery is a means of acquiring a good income with little effort. Most of these poorly equipped surgeons (?) start out as fee dividers.

What is true of general surgery is true of all other specialties. Eye, ear, nose and throat surgeons are almost as numerous as general surgeons. Not one of ten has had what might be considered adequate training, and probably not one out of three has had any training of any kind whatsoever, but, like Topsy, "just growed up" without any beginning.

To correct this evil the American College of Surgeons was organized, and there have been es-

tablished certain boards that issue certificates to ophthalmologists and to otolaryngologists, indicating that the owner of the certificate, after due examinaion and analysis of qualifications and training, is entitled to be rated and trusted as a specialist. But the trouble with fellowship in the American College of Surgeons, and the possession of a certificate from the ophthalmological board or otolaryngological board, is that very few know anything about such certification, and the public, most interested, goes on blissfully considering one man as good as another if he claims to be qualified, whether such claims are worthy of dependence or not. Usually his sign is bigger and he boasts more than the qualified man, and he works the churches, dinner clubs and lodges, so that from a commercial standpoint he may succeed as well or even better than the man of established ability. He may even, in the long run, by profiting from experience, measure up to the man who starts out well qualified, but the system is wrong just the same.

How are we going to rectify the trouble? Our solution of the problem would embrace a change in the policies of our teaching institutions. There must be more attention paid to general medicine and less to the specialties in the ordinary medical course. Men should be graduated from our medical colleges prepared to practice general medicine and not expected or even permitted to practice a specialty as a specialty until proven qualified. Likewise our boards of Medical Registration and Examination should stop giving rigid examinations in the specialties and require more of students concerning general medicine and its application. A well-trained general practitioner is good material for a good specialist, and we ought to make it a rule that no man can become a specialist until he first has been a good general physician.

Finally, there should be some method whereby we can make it necessary for those who desire to practice a specialty to become properly educated and adequately trained for the work selected. We even would go a step farther and say that specialists should be licensed as specialists after passing an examination that tests qualifications. Certainly some premium should be paid upon education, training and experience, and the public has a right to know who is qualified and who is not qualified so that ample protection is afforded.

FEES FOR EXPERT MEDICAL WITNESS IN INDIANA COURTS

There has been considerable misunderstanding among the physicians of Indiana concerning the right of a physician to demand and collect fees over and above those paid an ordinary witness when giving expert testimony in a court of law. In order to clarify the situation the matter was referred to the attorney for the Indiana State Medical Association, who has just informed us as follows:

"We have a statute in Indiana on that subject which was passed in 1881. It is Section 558, Burns Revised Statutes 1926, and reads as follows: A witness who is an expert in any art, science, trade, profession or mystery may be compelled to appear and testify to an opinion, as such expert, in relation to any matter, whenever such opinion is material evidence relative to an issue on trial before a court or jury, without payment or tender of compensation other than the per diem and mileage allowed by law to witnesses, under the same rules and regulations by which he can be compelled to appear and testify to his knowledge of facts relevant to the same issue.

"Prior to the adoption of that statute the question had been squarely raised in two cases, growing out of the same law suit in Allen county. In Buchman vs. the State, 59 Ind. 1, the opinion upon which the law was determined is found. In that case a physician was produced as a witness to testify in a rape case. The question propounded required his expert professional opinion. He refused to testify without the compensation of a professional fee, and his refusal to so testify unless so compensated, the court held was *not* contempt of court.

"Their reasoning was based upon certain provisions of the Constitution, particularly Section 21 of the Bill of Rights, which provides that, 'No man's particular service shall be demanded without just compensation.' The construction of that provision of the Constitution had been involved in other cases where attorneys had been called upon to defend and without compensation, and the court held that the attorneys' services could not be required without compensation in those cases where that question was presented. Then, reasons the court, 'If the professional services of a lawyer cannot be required in a civil or criminal case without compensation, how can the professional services of a physician be thus required? Is not his medical knowledge his capital stock? Are his professional services more at the mercy of the public than the services of a lawyer?'

"The court, following this line of reasoning, finally holds that, 'under the general principles of law and the Constitution of the State,' the physician cannot be compelled to give his professional services as an expert without compensation for such services, and that the compensation of the regular witnesses testifying to a fact is not compensation for particular services. That compensation must be on the basis of a professional fee and not on the basis of a witness fee.

"This case was decided by a divided court, three concurring in the decision. There was a dissenting opinion written by Judge Biddle. The

dissenting opinion is set out in the case that follows immediately after the one above cited. It is Dills vs. the State, 59 Ind. 15.

"The foregoing cases were decided in 1877. The Statute above quoted was enacted in 1881. If the reasoning in Buchman vs. State is to prevail, then the Statute itself is unconstitutional, for the basis of the decision in the Buchman case was that it would be contrary to the Constitution to demand such services from a physician without paying a professional fee for them. The Legislature could not abrogate that constitutional right if the courts determine that the right exists. On that divided opinion the right has been established, but it was established when there was no statute covering the subject. The statute itself, while theoretically it should not influence the court in determining the constitutional rights, might be a matter which in view of the divided opinion would resolve a doubt in favor of the Statute. In that event the physician who would refuse to testify as to an expert opinion in his professional capacity would be in contempt of court.

"The final determination of the constitutionality of the statute quoted awaits some physician refusing to give his expert opinion as a witness and then trying out whether or not he should be punished for contempt."

It is quite probable that neither attorneys nor courts will attempt to force any physician to give expert testimony against his will. There is an old saying that "You can lead a horse to water but you can't make him drink", so if an attempt is made to force a physician to give expert testimony against his will it is quite possible that the testimony will be valueless, as the witness probably would make every effort to make it so. The physician's knowledge has been acquired as the result of a very large expense of time, energy and money, and it is his stock in trade. As a matter of simple justice there is no reason why he should be compelled to give away that knowledge any more than there is reason for expecting an attorney to give away his knowledge, and the courts already have decided that an attorney is entitled to expert compensation for services. A test case would be of interest to the entire medical profession of the state, and any actual expense involved in such a case should be borne by the profession as a whole through the Indiana State Medical Association and not by an individual.

SLIGHTING PHYSICAL EXAMINATIONS

Some of the prominent men in the medical profession are saying some very sarcastic things concerning many of the men in the profession who seemingly are unable to make a physical examination. Dr. Frank Billings, of Chicago, a general practitioner, and one with a nation-wide reputation, says that while the average medical man is not incompetent to make a physical examination yet it is a fact that by habit he doesn't make the examination. He says that the poor in Chicago, which boasts of three million population, are the ones who get physical examinations because they go to the dispensaries connected with the university medical school and are stripped for examination. Fifty per cent of the well-to-do who go to physicians are *not* examined, and yet it is they who are able to pay for an examination and if the physician looks on the fee of the patient as the incentive for thoroughness he certainly should give competent attention to his well-to-do patients.

We might go Dr. Billings one better and say that the average doctor slights his work and makes superficial examinations, with resulting false or misleading diagnoses and the administration of inappropriate treatment, largely because he feels that the patient is not going to pay him adequately if the requisite time is given to an examination that is a real examination. As a matter of fact the average patient not only appreciates thoroughness but is willing to pay for the service that is based upon an intelligent understanding. The physician who says that he cannot afford to give so much time to his patient is an unsafe practitioner of medicine. The necessary time for a thorough examination, permitting an intelligent opinion of the condition presented, should be given every case or the case should not be accepted.

FEES FOR INDUSTRIAL WORK

Many Indiana physicians have had trouble in collecting fees for industrial work, and in the majority of instances the failure to recover has been due to the refusal on the part of insurance carriers to pay the bill rendered, either because they felt that they were not liable or because the bill was considered excessive. It is but natural that the insurance carriers should make an effort to get off with as little expense as possible, and some adjusters have no scruples when it comes to denying responsibility or browbeating the physician to secure a reduction in the fees charged even though the same may be reasonable.

It should be remembered that compensation, including fees for medical and surgical care, arose as a direct result of the recognition of the fact that industry should be charged with the cost of human wear and tear just as it always has been charged with the wear and tear of machinery. The law is not interested in whose fault it was, and negligence plays no part in compensation matters. Furthermore, the compensation awarded is intended to be fair and just to all concerned, and most compensation laws specify what may be considered as reasonable compensation, even for medical and surgical care, though considerable latitude is given compensation boards in arriving at conclusions. However, there always has been and always will be a certain amount of controversy with insurance carriers

concerning the amount of compensation awarded, and for the reason that insurance carriers desire to cut down their expense as much as possible, and are always conversant with the fact that often times the physician or the injured employee will compromise rather than fight, even though the amount received through compromise is less than either law or justice demands.

In connection with this subject it should be remembered that the insurance company has collected ample premium from the employer, and that the premiums are ample is attested by two outstanding facts, as pointed out by a Boston attorney who discusses the subject in the *New England Journal of Medicine* for July 5th, 1928. First, the insurance companies are putting up new and large office buildings and fighting for more and more compensation business, in spite of the constant wail that they are losing money on such business. Second, by the fact that bills before state legislatures to do away with insurance companies and substitute a state fund are fought frantically by insurance companies. If compensation insurance is a losing proposition why do they fight so hard to keep it?

In Indiana we have had, for the most part, compensation boards that have ruled judicially and impartially on all cases coming before the Board, and when properly presented there have been relatively few instances where physicians have complained about the award that has been granted as fees for services in compensation cases. Where complaints have arisen it has been found that an insurance carrier has attempted to browbeat the doctor into the acceptance of less than what was a reasonable fee, and rather than go to the trouble and expense of carrying the matter to the compensation board he has settled and ever afterward damned insurance carriers and compensation work of every description. In other cases there has been very evident intention on the part of some physicians to charge unreasonable fees for services, either through the presentation of a bill carrying an excessive charge for some specific service, or a bill that has been shamefully padded even though the individual fee would be considered reasonable for the service rendered had it been necessary or even been rendered at all. In such an instance the physician unjustly damns insurance carriers and industrial work in general.

It is the recognition of these inequalities and injustices that led the Indiana State Medical Association to establish what might be called a council for the purpose of analyzing any claims or disputes brought before it by members of the Association in connection with compensation claims in industrial cases, and that committee has acted so fairly as an arbitration committee that it has received and merited not only the confidence of the medical men of Indiana but the representatives of insurance carriers and members of the compensation board as well. At the head of this committee or council has been Dr. Frank H. Crockett, familiarly known as "Davy," who as a result of his fairness, integrity and judicial analysis has been able to conduct the affairs pertaining to this compensation question in a manner that has clarified the situation and made disputes and dissatisfaction less frequent than they were a few years ago. However, the Indiana State Medical Association will have to be on guard if there are not new and revised laws passed by our legislature, or a new interpretation placed on the laws at present on the statute books that will work injury to the individual physician who is called upon to do industrial work. The insurance carriers are always looking for the best of the bargain, and as a matter of pure business they will ask for and expect any concessions that will mean a profit to them no matter who is harmed thereby. Therefore, inasmuch as the interests of the worker and the medical man are identical, it would be well for the medical profession to join hands with labor organizations to secure and maintain just compensation laws and a fair interpretation of them.

BOARD OF HEALTH FREE CLINICS

Education concerning individual and community health receives the endorsement of the medical profession. *Hygeia* is doing a splendid work in this connection, and our own Indiana State Medical Association is sponsoring, through its Bureau of Publicity, weekly releases of health articles to be published in the lay press. In addition to this there are many prominent medical men in the state of Indiana who never have refused to speak before lay audiences on health conservation or some phase of disease prevention. However, the medical profession, individually and collectively, is opposed to free clinics open to all who come, either under the auspices of the state boards of health, nurses or welfare organizations of any kind whatsoever. Free clinics for the indigent are worthy of support, and are of distinct value in the promotion of health and happiness to say nothing of being an economic asset to the community served. Free clinics open to all classes of people, irrespective of ability to pay for services rendered, are a menace to public welfare, for they destroy self-respect and breed dependency and even pauperism. At the present time a department of our state board of health is spending some of the money raised by taxation in Indiana, supplemented by sums received through the Shepard-Towner Act, in sending paid representatives over the state to hold so-called health weeks or health demonstrations, in connection with which is a well advertised free clinic for which material is solicited from far and wide. These clinics would be a sorry failure except for the co-operation and assistance of reputable medical men who are being made willing tools for

the continuation of an enterprise that in the end is detrimental to the body politic, and as a mere side issue eventually will be the undoing of the medical men themselves. At these free clinics valuable gratuitous advice is given concerning the health of those who are presented to the clinic, and suggestions as to what is to be done in case abnormalities are found. Why should this valuable service be gratuitous to those able to pay, any more than it would be reasonable and consistent to give free food or clothing to those who are able to pay? We have no objection to a program which includes lectures by physicians or others, exhibits, and motion pictures on maternal, infant and child welfare, but we are unalterably opposed to the plan now in operation of imposing upon the charity and good nature of physicians by asking them to render valuable services gratuitously to individuals amply able to pay for the same, as we also are opposed to the practice of boards of health, health nurses, and welfare organizations in actually practicing medicine in direct competition with registered practitioners of medicine. This question is one that must be solved promptly if a whole lot more mischief is not to be stirred up as a direct result of the activities of a branch of our State Board of Health, encouraged by a variety of welfare organizations. The reputable medical men of Indiana should be either for or against this activity. There can be no middle ground. Our own opinion is that the medical men of Indiana should refuse to contribute longer to the free clinics enterprise started by the State Board of Health, and should insist that the State Board of Health must confine itself to its real function which, in the final analysis, is divorced from the private practice of medicine.

EDITORIAL NOTES.

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

This month we are giving you the preliminary program for the Gary session. Next month the completed and official program will be published, together with all official announcements.

The survey relative to the amount of dispensing and prescribing of drugs by Indiana physicians indicates that there are approximately 2,409 dispensers, 400 part dispensers, and 897 prescribers in the state.

We wonder if some of the Y. M. C. A. athletic associations and organizations of that character that have put physical therapy apparatus in their buildings and are charging for use of such apparatus are not really practicing medicine without a license?

The Gary session promises to be of exceptional merit in every way, and we are told that the social features are going to surpass anything that has gone before. Please don't make it too fine, for other cities in the state will feel that they cannot repeat.

Under "Society Proceedings" we are publishing the preliminary program for the Gary session to be held September 26, 27 and 28, 1928. Please read it carefully so that you may have some idea of all the good things in store for you. The complete program will be published in the September number.

A correction: We regret the omission of the name of Frank E. Wiedemann, M.D., of Terre Haute, from the heading of his manuscript, "Little Glimpses of Medical Africa", which was published in the July issue. It was a printer's last minute error and not an error of the editorial department.

While the August number of The Journal is going through the printers' hands, the editor is pursuing his favorite pastime in northern Canada, far from the haunts of men, and whether the fish bite or not he will feel sorry for any of his confreres who for any reason are not counting upon taking a *real vacation*.

Look out for the gyp subscription agents who come around to see you this summer claiming to be trying to earn enough money to carry them through another college year. Most of the subscription agents are fakers, but if you must patronize a subscription agent, make any payment direct to the publisher and not to the agent.

The editor of The Journal used to get just a little peeved when his wife beat him in a golf game, but when she played her way through a field of sixty and won the state golf championship for women he has decided to confine his activities to ping pong and save himself embarrassment. Women do have a way of holding their own in competition with men.

Concerning Transkutan, marketed by the Transkutan Company, Inc., New York, the *Journal of the A. M. A.* says that it appears that the public is to be exploited by means of news-

paper advertisements, and as is so often the case, physicians are to be the unsuspecting promoters of this proprietary nostrum. We hope that Indiana physicians will take warning.

SOME medical societies are meeting regularly with the Ladies Auxiliary. That is all right when there are matters in common to discuss, but for the most part our medical societies discuss scientific and business matters that are of little or no concern to women, and the discussion of which in the presence of women might be embarrassing even though the women present are the wives of the members.

IN commenting upon the practice of medicine by welfare associations and so-called health nurses, a correspondent in New York writes us that if the present tendency of welfare organizations continues, the medical men of this country before long will be mere figureheads, and will be doomed to valet service for the paid lay managers, secretaries and other officials of the welfare organizations.

WE hope that the members of the Indiana State Medical Association are taking notice of the work being done by the Bureau of Publicity of the Association. We are rather proud of the releases that have been sent to all of the lay publications of the state and published by a large majority of the newspapers of Indiana. These releases represent a lot of thought and energy, but then nothing can be accomplished without work.

WE would like to advise some of the medical welfare organizations that they will do a real service if they will institute and carry on a campaign of education of the public to the effect that good health may be protected and prolonged by periodic visits to the family physician who not only will advise intelligently but will make his charges consistent with the ability of the patient to pay, and he is always willing to do charity work where it is deserved.

SOME people have monumental nerve. Recently we received a letter from the author of a book in which he asks us to publish a eulogistic recommendation of his book for the benefit of the physicians of Indiana. So far as the book is concerned we never saw or heard of it before, and the author does not even deign to send us a copy for perusal but expects us to publish his recommendation of it. We can imagine that the book is about as weak as is his sense of propriety.

RECENTLY we heard a surgeon talk at length concerning the way to correct a variety of mistakes made in operating. It struck us that it would be far more appropriate to point out the manner in which mistakes may be avoided. There are too many would-be surgeons that do not know what they are doing inasmuch as they are not sufficiently familiar with the anatomy and relationship of parts, or sufficiently trained in the proper technique of operative work.

MANY physicians are being asked about the composition and value of Ovaltine, a so-called food preparation widely advertised under claims that belong in the patent medicine field. As a matter of fact a glass of good milk has more calories than the average recommended dose of Ovaltine. Its property of inducing sleep is similar to that of other warm drinks taken before retiring. Ovaltine is just another of those preparations that gains popularity and is sold as a direct result of extravagant advertising.

INDIANA physicians do not have to apologize for the character of advertising carried in THE JOURNAL, nor be embarrassed because THE JOURNAL does not maintain the highest standard of ethics and propriety in the acceptance of advertising. We have our faults, but one of them is not willingly accepting objectionable advertising because it means financial gain. We haven't the income of the *New York Journal of Medicine,* but thank God, we have principle enough to keep our advertising pages clean even at the expense of an income that might be derived from less rigid adherence to rules of propriety.

THE better business bureaus are fighting a new form of fraud in the sale of automobile tires. It seems that there is a fairly well established but unscrupulous practice of selling re-treaded automobile tires as first quality products. The names of well-known tire makers are used in connection with the retreading of old and worn-out tires, and it is hoped that the well-known manufacturers of tires will join in the crusade to put out of business the unscrupulous re-treaders. In purchasing tires it is well to buy new ones from firms having established reputations, or if purchasing retreaded tires, it is advisable to buy only those that come from factories of established reputation.

THERE should be a record-breaking attendance at Gary. The Lake County physicians are planning a world-beating program of entertainment, banquets, luncheons for the ladies, trips to the world-famous sand dunes and the great steel mills. The scientific committee is hard at work on a program that will stand up with the best of the many fine programs of the past years, and their chief aim is to present a program from which every individual physician can derive something of individual use to take home with him. Thus saith Tom, and Tom ought to know, for he is as busy as two hornets up a boy's trouser leg in efforts to round up all the activities of the Association.

We have received a reprint concerning a new serum therapy for the aging skin, and we have just been commenting on the possibilities of profit providing the serum will change the wrinkled and spotted skins on the faces of some old women who are trying to restore the bloom of youth and making such asses of themselves in trying to be "flappers." Few women would hesitate to mortgage their chances of getting into heaven if they could look young even if they do not feel young, and if there is a new serum that will do the trick, the man who originated it can make a fortune if he commercializes it. Perhaps it is worth it to make the grandmothers of sixty look like girls of eighteen.

The Bureau of Publicity of the Indiana State Medical Association has released a bulletin concerning the effects of sunlight and warning vacationists to avoid sunburn. It may be well to emphasize the fact that sunburn should not be neglected but cared for properly and conscientiously by a physician. It should not be looked upon lightly, as any sunburn is open to infection if there is blistering, and deaths from the secondary infection of a bad sunburn are not entirely uncommon. We might quote what the health department says, "Enjoy your vacation. Develop any tan from light yellow to deep brown, but if you value your comfort or your health, avoid sunburn."

Ira Lucas, of Rochester, New York, head of the Home Betterment Club and self-styled founder of the super-race of Caucasians, has been convicted of grand larceny and sentenced to serve from two to four years in the New York penitentiary. Lucas is one of the fellows who has preyed on the ills of humanity by specious promises to help or cure persons of bodily infirmities and he was able to extract much money from his dupes. Evidence shows that Lucas made representations which gave the dupes the impression that he was a physician and could cure body ills. The courts did well to convict him of fraudulent practices, and it is hoped that the sentence will have a deterrent influence upon others who want to follow in his footsteps.

In a previous number of The Journal we commented on the fact that certain institutions like the Y. M. C. A., Y. W. C. A., and athletic clubs are considering the advisability of installing physical therapy apparatus and charging for the use of such apparatus when used in the treatment of minor ailments. We now hear from the attorney of the A. M. A. to the effect that there is a question if those institutions are not guilty of practicing medicine without a license and should be made acquainted with the legal phase of their actvities. Probably someone would say "sour grapes" if a member of the medical profession offered objection to the addition of physical therapy apparatus to any lay institution, but perhaps it will not be long before they will burn their fingers and thus learn that the stove is hot.

Some man says, "Well, if I steal, it never will be less than a million dollars," and we are inclined to believe that the man who steals a million dollars will stand a better chance of going free than the man who steals a ham to feed a starving family. One of our editorial friends, in commenting upon purchasable medical testimony in court, says that he feels virtually sure that his opinion could not be swayed by a cash consideration so long as the amounts offered are not dazzlingly high. Well, to our notion, if it is a crime to steal a ham it also is a crime to steal a million dollars, and if you can purchase any man's testimony, whether the witness believes in the testimony or not, then that man is untrustworthy, whether in giving medical testimony or engaging in other activities requiring the exhibition of common honesty.

In England a bathing suit is a "sea suit", an elevator is a "lift", and a street car is a "tram". A qualified medical man, and especially one who has received some honor, may have official prefixes to his name, but he prides himself upon being called "Mr." instead of "Dr." Well, we often have objected to the term "Dr." when we note that such prefix is given the chiropractors, chiropodists, itinerant quacks, and medical pretenders of every description. When some good-natured fellow comes up, slaps us on the back and says, "Hello, Doc! How's your gizzard?" we feel like putting on our "sea suit" and going by "tram" to a convenient body of water and drowning our embarrassment, or going to the top of a ten-story building by "lifts" and ending it all by jumping off to the "poivement" below. Call us "Mister" if you will, but spare us from "Doc."

Concerning the value of the removal of tonsils and adenoid tissue, the United States Public Health Service (*Clinical Medicine and Surgery*, May, 1928) says that the incidence of sore throat seems to be twice as great in school children with defective tonsils as in those whose tonsils have been remvoed. This is also true in respect to respiratory diseases, rheumatism, heart disease, cervical adenitis and ear conditions. The incidence of diphtheria among children with defective tonsils seems to be much higher than among tonsillectomized children, and the result of the physical examination suggests that adenoids and large cervical glands, conjunctivitis, eye strain and decayed teeth all tend to be slightly more prevalent among children with defective tonsils than among children with normal tonsils or children whose tonsils have been removed.

IN July the government announced a new loan of $250,000,000 running for fifteen years, not callable under twelve years, with interest at 3⅜ per cent. Inside of three days over a billion had been subscribed, or four times the amount required by the government. Could anything more clearly indicate the confidence of the people in their government securities or prove the enormous amount of money in this country available on demand? The new loan is for the purpose of retiring what is left of the last Liberty loan, and, incidentally, this government, starting out with an indebtedness of over sixteen billion dollars at the close of the last war has paid off all of this indebtedness except about two billion dollars—and yet we hear some people talk about "hard times" and the poverty of the masses. The people in no other country on God's earth are as prosperous and have so many of not only the comforts but the luxuries of life.

THE advantage of brominized oil in bronchography in tuberculous patients was the subject of a paper presented before the clinical congress of the American College of Surgeons, at the Detroit session, by Samuel Iglauer, M.D., of Cincinnati, and Hugh Combs, M.D., of Hammond, Indiana. Eighteen of the twenty-two patients injected with bromithin were diagnosed as having tuberculosis. No permanent deleterious effects followed the injection, and the author states that the results of the experiment indicate the advisability of employing brominized oil when bronchography is contemplated in tuberculous persons. The roentgenograms obtained with bromithin are not as dense as with brominized oil, but this disadvantage is offset by the absence of irritating effects on the tissues. The endobronchial injection of warm bromithin can be very satisfactorily carried out by the intubation method combined with visual control by the roentgenoscope.

THE Indiana State Medical Association inaugurated the plan of having scientific exhibits at the annual sessions. It was proposed and managed by the late Frank B. Wynn, of Indianapolis. Our Association took it to an annual session of the A. M. A., and it proved such a hit that the A. M. A. adopted it as a regular feature and appointed Dr. Wynn as director of the exhibit, a position he held until his death. The scientific exhibits at the A. M. A. sessions have grown in size and importance, and are now of such varied character and of such an immensely important educational value that they form a leading feature of each annual session. However, for the last few years our state Association has dropped the exhibit feature, with regret to many, but we are pleased to announce that that feature will be resumed and there will be a beginning at the Gary session. A feature that has been inaugurated and developed by Indiana, and is of so much value to the medical profession should be continued by our Association.

PRACTICALLY all of the manufacturers of physical therapy apparatus urge physicians to buy ultraviolet machines, infra-red lights, sun lamps and diathermy apparatus on the ground that much money can be made from physical therapy treatment. Few of them say much about the conditions in which physical therapy is indicated, though some of the manufacturers go so far as to say that there is no real or imaginary ailment that isn't benefitted by some form of physical therapy treatment and consequently every patient that comes to the doctor's office can be made a source of profit. Isn't it ridiculous to have the practice of medicine so commercialized? A physician has little or no conscience if he administers a whole lot of useless treatments merely because he can get a fee for doing it. It is quite true that a physician earns his income through the practice of medicine, and he can increase his income by giving real service, but that does not mean that he should be dishonest with himself and with the patient merely because it means adding dollars to his income.

CONTRACT practice is rampant in some portions of the south. It is commercialized to the extent that certain organizations advertise to furnish first-class medical and surgical care and even hospitalization at cut-rate prices. Recently the medical society in Atlanta, Georgia, adopted a fee bill with the understanding that every reputable physician in the county would abide by it. A few of the fees are as follows: Obstetric cases, regular cases, $50; urologic examination at office, $10; office visits, $2; neurologic examination, $25; mental examination, $50; and regular visits, $3. The surgeons recommended that no action be taken in regard to fixing fees for surgical operations. The committee on eye, ear, nose and throat fixed as minimum fees for first office visits, $5, subsequent office visits, $3, tonsillectomy $50, standard fee for refraction $10, and radical mastoid operation, $250. The laboratories fixed a fee of $5 for Wassermann reaction, $10 for chemical analysis of the blood, $10 for pneumonia typing, $5 for malaria blood examination, and $10 for red, white and differential blood count and hemoglobin test.

IT is very clearly established that focal infections are the cause of a variety of systemic disturbances that impair health and shorten life. It has been proved that blood pressure has been lowered, neuralgic and rheumatic affections improved, and in fact health in general made better as the result of the removal of foci of infection. However, it is evident that results are not going to be the best until *all* foci of infection have been removed if possible, no matter where located.

Some men seem to think that tonsils and teeth offer the greatest field for infection, with systemic absorption, but it should be remembered that there are many other places in the body that can harbor foci of infection, notably the accessory sinuses, the ear, the gall bladder, the prostate and even hemorrhoids. The point is well taken by experienced internists that a diligent search should be made for all foci, with emphasis placed upon the necessity of removing the worst in the beginning, and the advantage of the increased resisting power brought about by cutting out any sources of infection.

A new scheme for working the public and taking work away from the legitimate practitioner of medicine is known as the American Medical Service Association which, in its literature, has the following to say: "If you found the wolf at your door in the form of sickness or injury, would it not be a great relief to know that all of your doctor, medicine and hospital bills were already paid? It costs twelve dollars a day to lie in a hospital and six dollars a day to be sick at your home. While you are well and able to earn you can pay a small monthly fee to a substantial organization and when sickness comes along you can have your choice of many doctors and any hospital. You are treated for anything from a cold to a major operation—everything paid. It is the best you can get."

We are just wondering what kind of physicians will accept employment by such an association as mentioned, and what kind of service would be furnished the public. Anyway, such an enterprise as seems to have gotten a start in New York state should be frowned upon and if possible put out of business. It is a menace to the people as well as the medical profession.

It is unbecoming an organization like the Y. M. C. A. and Y. W. C. A. to install in their buildings in connection with the swimming pools and gymnasiums a department devoted to physical therapy but confined almost exclusively to ultraviolet days, infra-red rays and day light lamps. Undoubtedly these enterprises are encouraged by the manufacturers of physical therapy apparatus. In some of the instances the institutions propose to charge for use of the physical therapy apparatus, thus not only entering the field of the practice of medicine, but receiving remuneration therefor. For the benefit of any physicians who may be on Y. M. C. A. or Y. W. C. A. committees appointed to consider such activities as mentioned, we desire to quote what has been said by the Council on Physical Therapy of the A. M. A. which is as follows: "Physical therapy must be recognized as a definite part of medicine to be practiced and controlled by a graduate physician. It should be used only as one of the triad of medicine, surgery and physical therapy. It should be prescribed only after careful physical and laboratory examinations of the patient have been made. It never should be prescribed except by physicians thoroughly trained in the use of physical agencies."

We are receiving all kinds of literature concerning special courses in physical therapy at prices ranging from thirty-five to one hundred dollars for the course. Usually the course lasts but a week, and sometimes only a few days. Concerning this matter we desire to repeat what has been said by the Council on Physical Therapy in the *Journal of the A. M. A.* of October 16th, 1926, which is as follows: "Physical therapy must be recognized as a component part of medicine, and patients requiring this type of treatment should be referred only to physicians trained in this specialty. In this way the use of these methods by charlatans will be largely eliminated. The making of physical therapists by courses of one or two weeks, often reeking with commercialism, must be condemned. The three to six-weeks' courses sponsored by reputable medical schools are frankly make-shifts, but do serve to show the would-be physical therapists the breadth of the subject. At least they effect the realization that such a period suffices only for establishing the purely mechanical details of technic, and the broader physiologic ground work on which, aided by his medical knowledge and common sense, one may attempt to erect a physical therapeutic super-structure."

Probably every physician has had the experience of caring for a family during that family's adversity and making no charge for his services, perhaps responding cheerfully for every call coming during a period of years, and discovers a little later that the family is and has been on "easy street" for some time and yet expect and accept gratuitous medical service without batting an eye. Perhaps the knowledge comes when it is discovered that the family has moved into a more pretentious home, is driving expensive automobiles, and enjoying the luxury of radios, phonographs and other expensive equipment. Such people are plain "spongers" and will continue as such unless compelled to bear their just burdens. Physicians probably do more than any others to pauperize and make dependent a class of people who should be self-supporting and possess an average amount of self-respect, and yet when it is suggested that a physician shall adopt some business methods in the practice of his profession and insist upon being paid by those who are able to pay, some "crabber" begins to talk about our mercenary tendencies. Usually the fellow who criticizes the medical profession the most is the one who hasn't a particle of the milk of human kindness in his make-up, and in comparison a Shylock would look like a philanthropist.

INDIANA physicians are being swamped with circulars offering bargain prices for surgical instruments, dressings and equipment. They will be wise if they are guarded in the acceptance of these offers, as in a few instances the so-called bargains cover cheap and almost worthless goods. Some of the dressings offered are products of the war period and have been stored in warehouses until age and the elements have made them almost valueless. Some of the surgical instruments offered for sale are of the cheapest manufacture and almost worthless. Usually this "gypping" is done by firms that you never heard of before, but we have learned that one very prominent physicians' supply house has bought several carloads of inferior supplies used by physicians and is selling them out at bargain prices but without recommendation as to quality. We believe that such a practice will act as a boomerang, and it should do so. If a firm with an established reputation is willing to put its name and stamp of approval upon goods sold at a sacrifice, that is another story, but to sell goods of uncertain manufacture and uncertain quality at bargain prices means that usually the purchaser is going to be stung and the selling firm gets a justifiable black eye in return. You generally get what you pay for in this world, and goods of quality seldom are sold at bargain prices.

IN the May number of *Clinical Medicine and Surgery* Dr. J. S. Langford, of Texas, says that we are not as safe from the plague that cursed the people of the past as we sometimes think, for rats have never been as numerous as they are now and they are the carriers of the plague and many other forms of infection. He calls attention to the fact that from 1896 to 1911 there were seven and one-half million deaths from the plague in India, and that in 1894 an epidemic occurred in Hong Kong, so virulent in type as to be called the black death. The plague is prevalent now in China, Japan, India, and other parts of the world in isolated cases. The best trained sanitary force in the world at present is the United States Public Health Service, and it has done a great work in preventing rats from coming ashore from steamers, and in exterminating the rodents existing in our seaboard cities. However, every community should wage a war on rats, and there should be co-ordination of every possible health conservation agency and of the school children, with poisons, traps, drives, terriers, cats, virus for the production of rat disease, and every invention and contrivance that can be used effectively to exterminate the rats. In commenting on this, the editor of *Clinical Medicine and Surgery* said that an international conference for the extermination of rats is to assemble May next in Paris. It is hoped that the work of this congress will stimulate nations and municipalities to the need of rat extermination and methods of carrying on the work.

MANY chiropractors are making the statement in advertising published in Indiana newspapers that chiropractic treatment is by far the best and most scientific treatment for acute diseases, including scarlet fever, diphtheria, and other communicable diseases. Could anything more detrimental to the public be published in a newspaper, and why should newspapers tolerate such advertising when it is so false and misleading? When epidemics of smallpox, typhoid, yellow fever, diphtheria, or scarlet fever invade a neighborhood, do the intelligent citizens of the community consult the chiropractors or would they do so? If not, why do we permit such misleading advertising to be published in our newspapers to betray and deceive the ignorant who deserve protection. When the chiropractors were clamoring for recognition by our legislators the plea was made by some of the legislators that no harm would be done in licensing chiropractors because chiropractic was only intended for some of the chronic diseases and was useful only as a massage. If they had any vision at all they would have recognized that chiropractors aim to treat anything and everything in the way of disease or abnormality of the human body. If a case of diphtheria is seen in its incipiency by a chiropractor who administers treatment, and the patient dies while under his care, we believe we are justified in saying that that child's life was lost needlessly through ignorance and maltreatment, but our legislature says, "Let those pretenders treat the sick and suffering according to their own ideas." The public pays the penalty.

AN Indianapolis reader of THE JOURNAL says, "You have a heluva lot to say about medical ethics, but don't you know that about nine-tenths of the medical men of Indiana don't know what the words mean? Why not print the code of ethics so that a lot of physicians, if they ever did know anything about the code, will have their memories refreshed if they take the pains to read what you print?"

If there is anything to be gained by printing the Code of Ethics in THE JOURNAL we will print it. Heretofore we have felt that if some meetings are opened with prayer then medical meetings ought to be opened with the reading of a chapter from the Code of Ethics. Some physicians do not need a code of ethics in order to practice medicine according to the Golden Rule, but there are others to whom a code of ethics means nothing even if committed to memory. You can't reform some physicians by cramming a code of ethics down their throats any more than you can make them decent by getting them to join a reputable medical society. A leopard does not change his spots, and if a physician is inclined to be unethical or

crooked he will be so no matter what efforts are made to reform him. We know some physicians who are so crooked that we always have wondered how they kept out of the penitentiary. Some of the undesirables have managed to get into reputable medical societies, and the members who voted favorably upon the applications did so on the false assumption that the undesirables could be reformed. It would be a good thing to hold some men on probation until a reputation for approved ethics and proper conduct has been established before taking them into the good company of our medical societies. It is easy to get the rascals in but it is an almost impossible task to get them out, for they insist upon clinging to positions that give them undeserved respectability.

The *Illinois Medical Journal* for April says that the Red Cross shows sporadic yet dangerous signs of resuming its post-war attempt to compete with the medical profession in the practice of medicine, and this in the face of the fact that a few years ago the House of Delegates of the A. M. A. passed resolutions condemning the activities of the Red Cross in this direction. It seems that in Henry county, Illinois, the Red Cross, in conjunction with a group of Rotary Club members, has started a children's clinic that cares for juveniles or cripples, and it is estimated that it costs the organization about fifteen thousand dollars per annum to do this work. The experience of Knoxville, Tennessee, is cited to show how pernicious the activities of the Red Cross may be when it attempts to practice medicine in competition with the physicians of the locality. At Knoxville the Red Cross sought to take over the entire practice of medicine, and in consequence there was a general disruption of the profession, and peace prevailed only after the Red Cross was eliminated in the care of the sick. The comment is made that following the Knoxville experience, and the resolutions passed by the A. M. A., "it is hoped that the Red Cross will settle down and mind its own business, but evidently such observation of the last commandment is not in the Red Cross textbook."

We might remind the *Illinois Medical Journal* that there are many who are meddling with the practice of medicine, including the pseudo-medical cults, public health officers, nurses, welfare organizations and lay societies of various beliefs and activities, so why not the Red Cross? If things keep on it will not be very long before a real, honest-to-God physician who has been graduated from an A1 university and served his apprenticeship as an intern in an accredited hospital will be only a little frog in a big puddle filled with leeches preying upon suffering humanity, and legalized to do it.

It comes with rather poor taste for the *Journal of Medicine of Cincinnati* to complain because the next session of the A. M. A. is not scheduled to be held in Cincinnati, and to make the claim that the Cincinnati representative was not even given respectful hearing at the Minneapolis convention. As a matter of fact several cities asked for the 1929 convention but only two of them, the ones voted upon, furnished data that meets all of the requirements of a convention city for the A. M. A. It is a gratuitous insult to say that politicians govern the matter, for that is not the truth. There are many things to be considered in selecting a convention city, not the least of which is the hotel accommodations. We require a large convention hall, with facilities for the commercial exhibits, the scientific demonstrations and the registration. This hall must be commodious and easy of access. Then there must be a large number of meeting places for the various sections and committees. A few years ago it was the custom to let sentiment prevail in balloting for a convention city, and as a direct result of that policy the Association did meet at some cities where the facilities were painfully inadequate and everyone went away dissatisfied. The House of Delegates therefore passed a resolution to the effect that cities desiring the convention must submit data in advance as to facilities afforded, and if the Board of Trustees find the facilities of any city desiring the convention to be adequate it passes favorably upon the application and that city is numbered among any and all others who offer adequate facilities. No political jugglery will get the convention for any city, though it is quite possible that a sense of fairness in distribution of the honor, as also a little sentiment, influences individual delegates in voting for their choice. However, the choice must be a city that can entertain the convention in a satisfactory manner, and it is idle talk to say that Portland, the place selected for the 1929 session, cannot be compared to Cincinnati in the way of facilities. The trouble with some of the cities desiring to entertain the Amercan Medical Association is that they do not want to put their cards on the table and have the selection made according to merit.

We have been quite amused to note the scrap that has been going on between the *Journal of the Michigan State Medical Society* and the *Illinois Medical Journal* concerning the growth of socialized medicine in the state of Michigan as charged by the latter journal and denied by the former. The *Illinois Medical Journal* says, in part, "it appears that the state of Michigan is well on its way, far and above any of the other states, to a program of socialized state medicine," and it specifically mentions the interference by the Michigan State University Hospital with the prerogatives of the medical profession through the hospital's competitive practice of medicine, made

possible by placing upon the individual taxpayers the burden of partially paying for the necessary overhead met with in caring for the sick and infirm. The *Illinois Medical Journal* says that if this is logic and good economics it should be carried further and result in the taxpayer paying partially for clothes, food, rent and other requisites of patients able to pay.

As a matter of fact we think that the *Illinois Medical Journal* has the best of the argument, for certainly sufficient proof can be furnished to indicate the trend of affairs in Michigan, insofar as that state's University Hospitals are concerned. We here in Indiana know something about the matter, for we know that many well-to-do patients residing in Indiana and paying absolutely no taxes in Michigan are permitted to go to the University Hospitals at Ann Arbor and receive practically gratuitous medical services. In fact we have been informed reliably by Indiana residents that all that is required of them at the Michigan University Hospitals is that a nominal fee for food and hospital care be paid, and the other services, no matter how valuable, are gratuitous. If that isn't paternalistic or socialized medicine we give up the argument. It is bad enough for well-to-do patients in Michigan to be served gratuitously by the University Hospitals without extending that service to people outside of the state who pay no taxes in Michigan. Whatever way you look at it, the principle is radically wrong, and the medical men of Michigan have a white elephant on their hands in supporting such a policy.

ACCORDING to the *New York Times,* seven interns comprising the entire resident staff of Unity Hospital, Brooklyn, New York, walked out of the institution on the night of March 5th, after one of their number was dismissed for refusing to administer an anesthetic for an operation. The superintendent stated that the interns had come to a common agreement to defy hospital discipline, having been guilty of continuous insubordination; they refused to write charts, to make rounds, and to perform duties required of them; they stayed out all night without permission; patients complained that some of these interns asked for payment for extra care; most of the group had served twelve of their fourteen to sixteen months of service; and within a few days after the walkout four of them had sent in letters of apology, but had made unsuccessful attempts to be reinstated.

The above situation presents no new factors, and to a greater or less extent the conditions exist in every hospital. Mob rule has no place in modern civilization—least of all in hospital administration. Graduates in medicine accept appointments as interns fully cognizant of the duties which properly belong thereto. It would seem nowadays that interns to too great an extent enter upon their hospital assignment with the idea of rendering the least possible service, of being away from the hospital as much as possible, and of "getting by" with as little attention to routine details as possible. It would seem to be sufferance upon their part. They do not appear to realize that an internship is of incalculable value in preparing them for their life work. The personnel of most hospitals is at a loss to understand the attitude of many of the interns toward their service.

There is no excuse for interns walking out. From the standpoint of servcie to humanity, to which they have consecrated their lives, they should control their tempers until their differences can be adjusted by those in authority. It is true that there are some superintendents who do not make the proper efforts to adjust controversies with the interns. When this occurs, then the latter should appeal their cause to the next superior control (hospital committee, president of board of trustees, etc.) If the board is made acquainted with the facts, the interns may be assured of an impartial hearing, and should abide by its decision—but *walk out? Never! — The Atlantic Medical Journal,* April, 1928.

DEATHS

WILLIAM J. BETHELL, M.D., of Winslow, died July 14, aged seventy-nine years. He had practiced in Pike county for fifty-four years.

EDGAR M. OUTLAND, M.D., of Indianapolis, died June 30, following an illness from ptomaine poisoning. Dr. Outland was sixty-seven years of age. He graduated from the Physio-Medical College of Indiana, Indianapolis, in 1890.

A. R. BURTON, M.D., of Princeton, died June 21, aged sixty-nine years. Dr. Burton was a member of the Gibson County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. He graduated from the Medical College of Ohio, Cincinnati, in 1882.

J. B. Christy, M.D., pioneer physician of Benton and Warren counties, died June 19, aged ninety-six years, at the home of his daughter in Chicago where he had been living the past five years. Dr. Christy began his practice at Rainsville, Warren county, in the early sixties and in 1870 moved to Boswell where he had resided until a few years ago.

MITCHELL C. CLOKEY, M.D., of Huntington, died July 16, aged fifty-five years. Dr. Clokey served in the medical corps of the United States Army during the World war and spent eleven months with the A. E. F. in France. He graduated from the Southwestern Homeopathic Medical College and Hospital, Louisville, in 1898. He was a member of the Huntington County Medical

Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in The Journal of The Indiana State Medical Association. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

The Inter-State Post Graduate Assembly will be held in Atlanta during the week of October 15th.

The seventeenth annual Safety Congress will be held in New York, October 1 to 5, at the Waldorf-Astoria.

The annual meeting of the Daviess-Martin County Medical Society was held July 24, at East Side park, Washington, Indiana.

Dr. Lynn W. Elston, of Fort Wayne, and Miss Marion M. Cook, of Valley City, North Dakota, were married in Minneapolis, June 27th.

The Association of Military Surgeons of the United States will hold its thirty-third annual meeting in Baltimore, October 4 to 6, at the Hotel Belvedere.

E. I. Wooden, of Rushville, has practiced medicine longer than any other physician in Rush county, having completed forty years of practice on July 4th.

Physicians of Whitley county held a meeting at Blue Lake, July 10th. Papers were presented by Dr. E. A. Hershey, of Churubusco, and O. F. Lehmbert, of Columbia City.

Contracts have been let for an eight-story addition to the Methodist Hospital of Indianapolis to cost more than $525,000. The new addition will accommodate two hundred patients.

Dr. Burghart Breitner, of the Eiselberg clinic, Vienna, and Dr. E. P. Sloan, of Bloomington, Illinois, conducted a clinic at Terre Haute under the auspices of St. Anthony's Hospital staff, July 10th.

The Noble County Medical Society held its meeting June 28th, at Wolf Lake, the guests of Dr. J. E. Luckey. Following the dinner, Dr. John Thompson, of Garrett, presented a paper on "The Acute Abdomen."

Dr. Rudolph B. Teusler, American physician, director of St. Luke's International Hospital, Tokio, Japan, is in this country to aid in a campaign to raise $3,500,000 for the hospital, $1,000,000 of which already is subscribed.

The Polk Sanitary Milk company, of Indianapolis, entertained the members of the Indianapolis Medical Society at the Sunlight Dairy Farms, Greenwood, Indiana, on July 20th, between the hours of three and nine p. m. Food, refreshments and all forms of outdoor entertainment were provided.

The American Board of Otolaryngology held examinations in Minneapolis, June 11th. Forty-nine applicants were examined, forty-six being granted certificates. The Board will hold an examination in New York City, October 12th, and in St. Louis, October 15th. Anyone wishing to come before this board may communicate with the secretary, Dr. W. P. Wherry, 1500 Medical Arts Building, Omaha, Nebraska.

The U. S. Civil Service Commission announces open competitive examination for dietitian and student dietitian. Applications must be on file with the Civil Service Commission not later than December 29. Examinations are to fill vacancies in hospitals of the U. S. Public Health Service and U. S. Veterans' Bureau throughout the country. Full information may be obtained from the Commission at Washington, D. C.

The twenty-ninth annual meeting of the American Roentgen Ray Society will be held at Kansas City, Missouri, September 25 to 28, with headquarters at the President Hotel. Attendants at the International Radiological Congress in Stockholm will make reports at this meeting. Details concerning the program may be had from the Program Committee, American Roentgen Ray Society, 1020 Rialto Building, Kansas City, Mo.

The U. S. Civil Service Commission announces open competitive examinations for occupational therapy aide in arts and crafts; trades and industries; gardening; and horticulture and floriculture. Also occupational therapy pupil aide (trades and industries) and occupational therapy assistant (trades and industries). Applications for the above positions must be on file with the Civil Service Commission not later than December 29.

The U. S. Civil Service Commission announces open competitive examination for graduate nurse, (visiting duty) and graduate nurse (junior grade). Applications must be on file not later than December 29. Competitors will not be required to report for examination at any place but will be rated on education, training and experience. Full information may be obtained from the U. S. Civil Service Commission at Washington, D. C.

The United States Civil Service Commission announces open competitive examinations for physiotherapy aide and phsyiotherapy pupil

aide; applications for such positions must be on file with the Commission at Washington, D. C., not later than August 21, October 9, and November 27. Examinations are to fill vacancies in the Field Service of the United States Veterans' Bureau and United States Public Health Service, and elsewhere. Complete information and application blanks may be obtained from the United States Civil Service Commission, at Washington, D. C.

MORE than one-hundred physicians have signed up for the special two-day short course, which will be conducted by the Indiana Tuberculosis Association, during the months of August and September. In order that it may be possible for physicians to attend without much loss of time, several of the sanatoria of the state will be used as teaching centers for the physicians in that vicinity. The purpose of the course is to acquaint the physicians with recnet progress in the treatment of tuberculosis. The course will be held in the following institutions on the dates indicated and the following physicians will conduct the course: Places: Irene Byron Sanatorium, Fort Wayne, August 23 and 24; Sunnyside Sanatorium, Oaklandon, September 11 and 12; Healthwin Sanatorium, South Bend, August 16 and 17; Lake County Tuberculosis Sanatorium, Crown Point, August 29 and 30; Indiana State Sanatorium, Rockville, September 13 and 14; Boehne Tuberculosis Hospital, Evansville, September 27 and 28. Faculty: Dr. E. M. Amos, Indianapolis; Dr. Eric Crull, Fort Wayne; Dr. St. C. Darden, South Bend; Dr. H. S. Hatch, Oaklandon; Dr. Alfred Henry, Indianapolis; Dr. G. C. Johnson, Evansville; Dr. G. E. Mills, Evansville; Dr. J. P. Parramore, Crown Point; Dr. J. H. Stygall, Indianapolis; Dr. Amos Carter, Rockville.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:
- Tablets Ephedrine Hydrochloride—Abbott, ¼ grain.

Deshell Laboratories, Inc.:
- Petrolagar (Unsweetened).

Mead Johnson & Co.:
- Mead's Standardized Cod Liver Oil, Flavored.

Parke, Davis & Co.:
- Glaseptic Ampoules Ephedrine Sulphate—P. D. & Co., 0.05 Gm. (¾ grain), 1 cc.
- Capsules Ephedrine Sulphate—P., D. & Co., 0.05 Gm. (¾ grain) Paroidin.

Prophylacto Mfg. Co.:
- Capsules Ephedrine Hydrochloride — Pemco, 0.3 Gm.
- Capsules Ephedrine Hydrochloride — Pemco, ¼ grain.

E. R. Squibb & Sons:
- Squibb's Vitavose.

Swan-Myers Co.:
- Gentian Violet Capsules — Swan-Myers, 1 grain.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

June 19, 1928.

Meeting called to order at 4:45 P.M.

Present: William N. Wishard, M.D., Chairman; J. A. MacDonald, M.D., and Thomas A. Hendricks, Executive Secretary.

The minutes of the meeting held June 4 read and approved.

The following bill was approved for payment:
Railroad fare from Indianapolis to Madison, Indiana, for speaker to address meeting.....$2.28

The release—Summer Care of Young Children—read, corrected, and approved for publication Monday, June 25.

Report of medical meeting:

March 13, Rotary Club, Madison, Indiana, "Effect of Modern Business Life on Heart Disease."

Meeting to be held:

June 19, Rotary Club, Sheridan, Indiana. Subject: "Prevention of Disease in the School Child."

Letter received from the Director of the Division of Infant and Child Hygiene of the Indiana State Board of Health thanking the Bureau of Publicity for the May Day announcement issued by the Indiana State Medical Association.

Letter and pamphlet received from the Committee on the cost of Medical Care. The secretary was instructed to summarize pamphlet for next meeting of the Bureau.

Article entitled, "The Toledo Experiment (Two Years of Organized Medical Publicity)", by the Director of Education of the Toledo Academy of Medicine, Toledo, Ohio, reviewed by the Bureau. The Bureau wishes to compliment this organization upon its work but believes that the writer errs when he says that Toledo has "priority rights" in the field of newspaper publicity. The secretary was instructed to write a friendly letter to the director calling attention to the fact that in 1926 when Toledo started this work publicity releases for the press were being prepared by the Indiana State Medical Association and several other associations.

The following radio talks have been prepared by the Bureau to be given over Station WFBM of the Indianapolis Power and Light Company:

June 9, Annual Health Examinations.
June 16, Prevent Hay Fever Now.
June 23, Some Facts About Yeast.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole June 25, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

July 2, 1928.

Meeting called to order at 4:45 P. M.

Present: Wm. N. Wishard, M.D., chairman; M. N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held June 19 read and approved.

The following bills were approved for payment:

A. B. Dick Company	$2.50
Central Press Clipping Company	5.00
	$7.50

The release "Sunshine," read, corrected and approved for publication Saturday, July 7.

The release "A Modern July Fourth," for publication Saturday, June 30, had been approved through correspondence with members of the Bureau as no publicity meeting was held on Monday, June 25.

Report of medical meeting:

June 19, Rotary Club, Sheridan, Indiana. "Prevention of Disease in the School Child."

Meeting to be held:

July 30, Lions Club, Greenwood, Indiana. Speaker to be obtained.

The following brief outline on the phamphlet entitled, "The One Great Outstanding Problem," prepared by the Committee on the Cost of Medical Care of the American Medical Association, was presented to the Bureau:

"Purpose of Committee. A Committee has been created to study the cost of medical care under the direction of and in co-operation with the American Medical Association, the United States Public Health Service, and the Metropolitan Life Insurance Company. This committee is to devote five years of study to the subject "The High Cost of Ill Health."

"Viewpoint of Committee. 'It is approaching the problem without bias and without preconceived ideas of what the solutions will be.'

"Personnel. The committee includes representatives of various medical organizations 'and of other long established and conservative agencies, a circumstance which should insure reasonableness in the committee's recommendations.'

"Fundamental Questions to Be Studied.

1. The extent to which the burden of cost of medical care and the incidence of sickness falls upon various economic and social classes in different types of communities.
2. The variation in cost to individual families.
3. Financial returns to physicians in various types of practice.

"Olin West, M.D., Secretary of the American Medical Association says: 'The one great outstanding problem before the medical profession today is that involved in the delivery of adequate, scientific medical service to all the people, rich and poor, at a cost which can be reasonably met by them in their respective stations in life.' "

The Bureau suggested that the county societies co-operate with this committee in its survey in every way possible.

Article entitled, "Approaching High Schools with a Health Program," by Arthur L. Trester, Permanent Secretary of the Indiana High School Athletic Association, which appeared in the *Hoosier Health Herald,* the official journal of the Indiana Tuberculosis Association, was reviewed by the Bureau. The Bureau especially commended and approved the following paragraph from this article:

"The following elements should probably be stressed in a health program in High School:

1. Thorough Health Examinations at least annually and probably more often in order to detect infectious and contagious diseases, to discover physical defects and chronic ailments and to secure a fair appraisal of the health status of the individual student.
2. Healthful Environment at home, at school and in the community.
3. Instruction and Training in Health Work—knowledge, ideals, habits and attitudes.
4. Physical activity in which the *play* element predominates, graded, graduated and adapted to adolescents and pre-adolescents."

A report was made that the following radio talk was prepared by the Bureau and was given over Station WFBM June 30: "A Modern July Fourth."

Letter received from an Indianapolis physician asking that arrangements be made for a scientific exhibit at the annual meeting of the Indiana State Medical Association at Gary, September 26, 27 and 28. In connection with this subject the Bureau recalled that the scientific exhibit which is now a feature of the annual meeting of the American Medical Association originated in Indiana.

The first scientific exhibit at an American Medical Association meeting was made by the late Frank B. Wynn, M.D., in June, 1897, at the Columbus, Ohio, meeting. This exhibit reproduced and enlarged an exhibit previously made at the state meeting of the Indiana Association. The exhibit at the Indiana State Medical Association had resulted from the accumulation by Dr. Wynn of interesting pathological specimens on "case night" which was held each month by the Indianapolis Medical Society. Dr. Wynn, with co-operation of the president of the Indiana State Medical Association and the assistance of physicians throughout the state, presented an interesting exhibit at the American Medical Association meeting consisting of pathological specimens and unusual cases. The exhibit was held in a vacant store room near the meeting place of the association. So much interest was developed in the exhibit that it was adopted as an annual feature of the American Medical Association meetings and a special committee, of which Dr. Wynn was chairman, was appointed. There was soon added to the pathological exhibit other exhibits of scientific interest. The name of the exhibit was subsequently changed from the pathological exhibit to the scientific exhibit. Dr. Wynn served as chairman of this exhibit committee for several years when he finally resigned. His enthusiasm was so great for this work that Dr. W. W. Keene, president of the American Medical Association, two or three years after the establishment of the exhibit, spoke of Dr. Wynn as "the devoted prisoner of the pathological exhibit.'

As the scientific exhibit had its origin in Indiana the Bureau feels that such exhibits should be arranged as part of the annual meeting in the future.

As the Council of the Indiana State Medical Association at its regular mid-winter meeting decided not to have a scientific exhibit this year, the secretary was instructed to write a letter to the chairman of the Council enclosing a copy of the letter which the Bureau recently received suggesting the exhibit and asking if the Council will approve holding a voluntary exhibit this year. The matter is also to be taken up with the chairman of the Arrangements Committee. If this approval is received further steps are to be taken for a voluntary exhibit at Gary.

Request was received from the Director of the Child Hygiene Division of the Indiana State Board of Health for the Indiana State Medical Association to be one of the sponsors of Child Health Week at the Winona Lake Chautauqua, July 9 to 13, 1928. The Bureau instructed the secretary to write the Director of the Child Hygiene Division that the Bureau did not feel that it had the power to give its authority as a sponsor for this meeting without consulting the officers of the State Association and members of the various other committees of the association. The Bureau expressed itself as feeling that as this demonstration is being held in Kosciusko County that the approval of the local county society should be obtained by the Director of the Child Hygiene Division. It suggested that the names of doctors giving demonstration work should not appear in the press and that each child examined should be referred to its family physician for treatment.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole July 9, 1928.

WM. N. WISHARD, M.D.,
Chairman.

THOS. A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

July 9, 1928.

Meeting called to order at 4:45 P. M.

Present: Wm. N. Wishard, M.D., Chairman; M. N. Hadley, M.D., and Thomas A. Hendricks, Executive Secretary.

The minutes of the meeting held July 2 read and approved.

The following bill was presented to the Committee:

Gaw-O'hara Envelope Company:

5,000 No. 6 ¾ White Bond Envs		$16.15
10,000 No. 10 Silver King Stk. Envs.		29.80
		$45.95

The Committee approved the payment of $29.80, the cost for large envelopes which are used mostly to send out the Bureau releases. The remainder of the bill was to be presented to the Executive Committee for approval.

The release — Sunstroke — read, corrected and approved for publication Saturday, July 14.

A report was made that a radio talk upon "Sunshine" prepared by the Bureau, was given over Station WFBM, Saturday, July 7.

Speaker was obtained for meeting of the Lions' Club at Greenwood, Indiana, July 30.

Letters from the Chairman of the Council, Editor of THE JOURNAL and Chairman of the Arrangements Committee in regard to the suggested scientific exhibit at the annual meeting of the Indiana State Medical Association at Gary September 26, 27 and 28. The Chairman of the Council wrote that he would approve a scientific exhibit provided that it incurred no expense to the State Association. The Editor of THE JOURNAL expressed himself as being in favor of the scientific exhibit. The Chairman of the Arrangement Committee said he thought that if a scientific exhibit was approved by the Chairman of the Council space could be obtained for this at Gary. The secretary was instructed to write to the Dean and the Assistant Dean of the Indiana University School of Medicine telling them of the fact that a scientific exhibit may be held at this year's state convention and suggesting that the University make an anatomical, pathological, or any other exhibit that it so desires.

Letters were received from the Executive Committee regarding the Child Hygiene Conference at Winona Lake.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole July 16, 1928.

WM. N. WISHARD, M.D.
Chairman.

THOS. A. HENDRICKS
Secretary.

JEFFERSON COUNTY MEDICAL SOCIETY

The meetings of the Jefferson County Society during 1928 have been held monthly, the fourth Monday of each month, instead of former dates as published in THE JOURNAL.

Following is a notice of our last meeting: The regular June meeting of the Jefferson County Medical Society was held July 2, 1928, being postponed to that date. At 6 p. m. dinner was served at the Hillside Hotel followed by the scientific session. A paper was presented by Dr. N. A. Kremer, of Madison, on the "Acute Infectious Exanthemata." Symptoms, treatment and particularly differential diagnosis of these diseases, were well presented. An interesting feature was the presentation of many photographs of smallpox obtained during several epidemics.

O. A. TURNER, M.D.
Secretary.

COUNTY SOCIETY PROGRAMS

(This is a brief resumé of the talk made by Dr. Moore at the Annual County Secretaries' Conference at Indianapolis April 26. Talks and discussions of various topics which are interesting to County Society secretaries will appear in this column each month.)

At the beginning of my service as secretary of the Knox County Medical Society attendance at meetings averaged about five members out of a possible thirty-three. During the last year attendance has averaged sixteen. The purpose in mentioning this personal experience is to bring out the point that the attendance at meetings can be improved by furnishing better programs. I am unable to explain this personal experience any other way. After all, attendance at meetings depends upon interest. Interest in the meetings is created or destroyed, depending upon whether or not the member feels that he has profited by attending previous meetings. It is true that there are other activities of the county society which have their influence in creating interest, but I believe that the good program is the key-note of the entire situation. If I have nothing else to offer at this meeting, let me urge that each of you pay particular attention to your programs.

The following are some points which I think worthy of consideration relative to this subject:

1. At the beginning of each year a tentative program for the entire year should be arranged by the secretary and placed in the hands of each member.

2. Arrange program for the year with ten meetings in all, one annual meeting and at that time a program a little out of the ordinary, a little more elaborate than usual. Also thought of inserting into that annual program possibly one social meeting at which the ladies are present.

3. Possibility of holding annual picnic with or without ladies.

4. In regard to the regular monthly meeting, I believe it should be arranged at least a month in advance.

I have listed six points which I believe should be a part of each monthly program:

1. Scientific paper.
2. Case history presentation.
3. Cases for clinical demonstration.

Arrange with speaker you procure to announce his subject early enough so that you can see some of the doctors in your county and get them to bring cases with them for clinical presentation. Discussion should follow paper.

4. There should be some type of entertainment—music, etc.

5. Joint meetings with adjoining county societies is excellent.

6. Also believe that a periodic inter-change of speakers is an excellent idea—instead of a paper read by a member of our local society have someone from an adjoining county society. There is something psychologically wrong with having a local speaker. Don't believe it works.

In conclusion, I wish to express my appreciation for the opportunity to be present at this meeting. I believe that such meetings should be perpetuated by all means. It offers an excellent opportunity for every secretary to air his own troubles and to receive helpful advice from his fellow secretary. I can not help believing that such meetings as these will be of tremendous importance in building up organized medicine in the State.

THE GARY SESSION

The Indiana State Medical Association will meet this year at Gary, Lake County, Indiana, Wednesday, Thursday and Friday, September 26, 27 and 28. This year an additional attraction to the usual high class scientific program and entertainment features which have marked the annual sessions of the State Association in the past will be the visit to the rapidly growing Calumet district with its industrial plants and sand dunes The Lake County Medical Society has made elaborate plans for entertainment for the physicians and their families while the scientific program committee has arranged its part of the meeting with the thought of interesting the general practitioner. As a result all meetings will be general in nature and the sections will meet only to elect officers and conduct routine business.

The big feature event of the entertainment program will be the trip through the steel mills, personally conducted by W. P. Gleason, General Superintendent of the Illinois Steel Corporation. This trip, which will be made on flat cars, will take more than four hours—starting at one o'clock Wednesday afternoon. Due to this trip, the annual golf tournament has been moved to Wednesday morning and the House of Delegates will go into session at 6:30 o'clock in the evening instead of the afternoon. The Council meeting will be held at 11 o'clock in the morning. The usual get-together and smoker will be held in the evening in the ballroom of the new Hotel Gary which will be official convention headquarters.

All events are scheduled on daylight savings time. For the men the second day of the session and the morning of the third day will be devoted entirely to scientific work with the exception of the breakfast meeting of the House of Delegates and the final meeting of the Council on Friday morning and the banquet on Thursday evening. The ladies will be entertained with a theater party, several teas, a bridge party and a special trip of their own through the steel mills and the dune region.

The preliminary scientific program follows:

THURSDAY, September 27

Morning Session

8:30 A.M. Meeting called to order by President George R. Daniels, M.D., Marion.

8:45 A.M. Address of welcome; speaker to be named by General Arrangements Committee, Lake County Medical Society.

9:00 A.M. President's address—George R. Daniels, M.D.

9:30 A.M. "Tuberculosis," W. H. Ordway, M.D., Assistant Medical Director, Metropolitan Life Insurance Company, Mount McGregor, New York.

10:00 A.M. Discussants: (1) J. A. Wynn, M.D., Indianapolis.
(2) Eric A. Crull, M.D., Fort Wayne.

10:30 A.M. Palmer Findley, M.D., President of The American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Omaha, Nebraska. Subject, "Pelvic Peritonitis."

11:00 A.M. Discussants: (1) A. M. Mendenhall, M.D., Indianapolis.
(2) ----------

11:30 A.M. Henry Frederick Helmholz, Professor of Pediatrics, University of Minnesota Medical School. Subject, "Pediatrics."

12:00 M. Discussants: (1) Milo K. Miller, M.D., South Bend.
(2) Reuben A. Craig, M.D,. Kokomo.

Afternoon Session

2:00 P.M. W. D. Little, M.D., Indianapolis. Subject, "Thyroid."

2:30 P.M. Discussants: (1) Miles Porter, Sr., M.D., Fort Wayne.
(2) A. B. Coyner, M.D., Lafayette.

3:00 P.M. Otis B. Nesbit, M.D., Gary. Subject, "Public Health in the Schools."

4:00 to 4:30 P.M. Udo Julius Wile, M.D., Professor of Dermatology and Syphilology, University of Michigan Medical School. Ann Arbor, Michigan. Subject, "Syphilis."

4:30 P.M. Discussants: (1) Herman M. Baker, M.D., Evansville.
(2) O. L. Fisher, M.D., Richmond.

5:00 P.M. Meeting of sections and election of section officers to follow immediately upon close of scientific meeting.

FRIDAY, SEPTEMBER 28

Morning Session

9:30 to 11:30 A.M. Symposium, "Diabetes." This subject is to be discussed from the standpoint of interest to the general practitioner and not from the standpoint of the specialist.
Joseph C. Beck, M.D., Associate Professor, University of Illinois College of Medicine.
Harry Searles Gradle, M.D., Chicago.
Sidney Strauss, M.D., Associate Professor of Medicine, University of Illinois College of Medicine.

11:30 A.M. Discussants: (1) Roscoe Hamilton Beeson, M.D., Muncie.
(2) Marcus Ravdin, Sr., M.D., Evansville.
(3) C. P. Clark, M.D., Indianapolis.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books received since July 1, 1928:

Goiter Prevention and Thyroid Protection. By Israel Bram, M. D., Illustrated. 327 pages. Cloth. Price $3.50 F. A. Davis Company, Philadelphia, 1928.

Dictionary of American Medical Biography. Lives of Eminent Physicians of the United States and Canada, from the earliest times. By Howard A. Kelly, M. D., LL. D., Baltimore, and Walter L. Burrage, A. M., M. D., Boston. 1364 pages. Cloth. D. Appleton and Company, New York and London, 1928.

The Eye. By C. W. Rutherford, M. D., F. A. C. S., associate in Ophthalmology, Indiana University School of Medicine. 403 pages, with 305 black and white figure and 12 original colored plates. D. Appleton

and Company, New York and London, 1928. Cloth. Price $7.50.

THE NOSE, THROAT AND EAR. By John F. Barnhill, M. D., F. A. C. S., professor of Surgery of the Head and Neck, Indiana University School of Medicine. 604 pages with 452 illustrations. Cloth. Price $7.50. D. Appleton and Company, New York and London, 1928.

SURGICAL CLINICS OF NORTH AMERICA. (Chicago Number) Volume 8, Number 3. For June 1928. 219 pages with 49 illustrations. Cloth, per clinics year, $16.00; paper, $12.00. W. B. Saunders Company, Philadelphia, 1928.

CALCIUM THERAPY. By John Aulde, M. D. 420 pages. Cloth. Price $5.00. John Aulde, M. D., Philadelphia, 1928.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

POLLEN EXTRACTS—SWAN-MYERS (NEW AND NONOFFICIAL REMEDIES, 1928, p. 38).—Also marketed in packages of one vial containing 2,000 units. Swan-Myers Co., Indianapolis.

CONCENTRATED POLLEN EXTRACTS—Swan-Myers.—In addition to the products listed in New and Nonofficial Remedies, 1928, p. 30, the following product has been accepted: Biennial Sage Concentrated Pollen Extract—Swan Myers. Swan-Myers Co., Indianapolis.

GLASEPTIC AMPOULES SOLUTION GLUCOSE, 50 PER CENT, 20 CC.—Each ampule contains dextrose, U.S.P., 10 Gm., in distilled water, to make 20 cc.; buffered with sodium citrate, .25 per cent. Parke, Davis & Co., Detroit.

GLASEPTIC AMPOULES SOLUTION GLUCOSE, 50 PER CENT, 50 CC.—Each ampule contains dextrose, U.S.P., 25 Gm., in distilled water, to make 50 cc.; buffered with sodium citrate, 0.25 per cent. Parke, Davis & Co., Detroit. (*Jour. A.M.A.*, June 16, 1928, p. 1945).

BISMUTH SODIUM TARTRATE-SEARLE.—A basic sodium bismuth tartrate containing from 72.7 to 73.9 per cent of bismuth. Its use is proposed as a means of obtaining the systemic effects of bismuth in the treatment of syphilis (See Bismuth Compounds, New and Nonofficial Remedies, 1928, p. 104). The product is administered by intramuscular injection. It is supplied in the form of 2 cc. ampules containing bismuth sodium tartrate—Searle, 0.03 Gm., benzyl alcohol, 0.040 Gm., sucrose, 0.5 Gm. in water sufficient to make 2 cc. G. D. Searle & Co., Chicago.

TABLETS EPHEDRINE HYDROCHLORIDE—ABBOTT, ¼ GRAIN.—Each tablet contains ephedrine hydrochloride—Abbott (New and Nonofficial Remedies, 1928, p. 176) ¼ grain. Abbott Laboratories, North Chicago.

CAPSULES EPHEDRINE SULPHATE—P., D. & Co., 0.05 Gm. (¾ grain).—Each capsule contains ephedrine sulphate—P., D. & Co. (New and Nonofficial Remedies, 1928, p. 178) 0.05 Gm. Parke, Davis & Co., Detroit.

GLASEPTIC AMPOULES EPHEDRINE SULPHATE—P.,, D. & Co., 0.05 Gm. (¾ grain), 1 cc.—Each ampoule contains ephedrine sulphate—P., D. & Co. (New and Nonofficial Remedies, 1928, p. 178) 0.05 Gm. in 1 cc. Parke, Davis & Co., Detroit. (*Jour. A.M.A.*, June 30, 1928, p. 2103).

PROPAGANDA FOR REFORM

THE ANTERIOR LOBE OF THE HYPOPHYSIS.—In 1921, Evans and Long demonstrated specific endocrine effects, such as gigantism and sex disturbance from parenteral dosage of mammals with beef anterior hypophysis after failure in a long series of massive oral administrations. Putnam, Teel and Benedict have prepared a sterilized extract of the anterior lobe of the hypophysis that has been used in animals with the production of changes which appear to be specific. It serves to repair some and perhaps all of the disabilities produced by hypophysectomy. The extract has been used in one human case of pituitary insufficiency, apparently with temporary benefit. (*Jour. A.M.A.*, June 2, 1928, p. 1791).

IRON IN THE TREATMENT OF ANEMIA.—In most cases of nutritional anemia and secondary anemia, and more or less in primary anemia, the administration of iron is of benefit. The administration of iron intravenously or subcutaneously is rarely necessary or desirable. Recent experiments with rats confirm previous work, that small doses of iron are sufficient to cause improvement. In a recent investigation it was found that the best hemoglobin improvement was caused by administering ferric acetate, ferric albuminate, ferric chloride and ferric citrate. (*Jour. A.M.A.*, June 2, 1928, p. 1792).

ALUCOL NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that Alucol, marketed by The Wander Co., Chicago, is stated to be colloidal aluminum hydroxide to be used therapeutically as an antacid. The Wander Co. was informed that the Council would accept Alucol (a) if marketed in the United States under a descriptive name, such as colloidal aluminum hydroxide with definite standards of identity and uniformity that shall be found acceptable; (b) if acceptable evidence is offered to show that the use of the product does not produce harmful effects, and (c) if the therapeutic claims are based only on its protective action on the gastric mucosa and on its moderate reduction of gastric acidity. It was also stipulated that the claims should not (unless acceptable evidence is offered to the contrary) imply that while it reduces acidity it does not retard gastric digestion, and shall omit the unsupported statements concerning the harmfulness of sodium bicarbonate, magnesium oxide and other alkalis currently used in the treatment of hyperacidity. The product was not made acceptable and hence the Council rejected Alucol and publishes its report for the information of the medical profession. (*Jour. A.M.A.*, June 9, 1928, p. 1871).

LENS EXTRACT (MULFORD) NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that Lens Extract, marketed by the H. K. Mulford Co., is stated to be "A sterile solution of the protein from the eye lens of cattle, standardized to contain 2 per cent protein with 0.5 per cent phenol added as a preservative." The product is based on the work of Dr. A. Edward Davis and has been under consideration by the Council since 1924. A review of the available evidence and the advice of the Council's consultants indicated that not only is there no evidence that the substance is beneficial but that, being useless, the employment of lens extract in the treatment of cataracts is likely to result indirectly in harm to the patient suffering from the disease. The Council therefore declared Lens Extract (Mulford) unacceptable for New and Nonofficial Remedies. (*Jour. A.M.A.*, June 9, 1928, p. 1871).

COPPER IN NUTRITION.—The announcement made by a group of biochemical investigators from the University of Wisconsin regarding the function of copper as a supplement to iron for hemoglobin formation under certain conditions, has created much interest. It is important to sound a warning against generalizations on the basis of these observations, for already copper is beginning to be lauded by uncritical and unscrupulous persons as a cure-all for the entire gamut of the widely different anemias. It was shown that a trace of copper supplied along with iron salts eliminated the anemia hazard from experimental diets fed to rats. Thus, copper appears to be a factor in the building of hemoglobin. For the present it is futile to speculate on the function of copper in nutrition. The most that can be asserted at this time is that we may need to reckon with traces of copper in some of the most fundamental reactions of the organism. (*Jour. A.M.A.*, June 9, 1928, p. 1872.

STANDARDIZATION OF EPHEDRINE PREPARATIONS.—The American Medical Association Chemical Laboratory, in co-operation with the Council on Pharmacy and Chemistry, has been in considerable measure instrumental in arriving at the highly satisfactory condition that exists

with regard to the market supply of this drug in America. The Laboratory studied the problem carefully and tests and standards were elaborated at the time when ephedrine and its compounds were just becoming popular. The standardization of new remedies is one of the most important functions of the laboratory. Unless the products are standardized, comparable clinical investigations cannot be reported. The first step in the investigation by a therapist of a new remedy is the determination of its chemical composition and purity. (*Jour. A.M.A.*, June 9, 1928, p. 1873).

Transkutan. — "Transkutan" is marketed in the United States and Canada by Transkutan, Inc., New York City. It is a German product which comes in bottles holding about four and one-half ounces with a gaudy label in German. The method of introducing this German product to the American market is ingenious. While physicians are detailed, newspaper advertising addressed to rheumatic sufferers is also used. Transkutan is claimed to have produced remarkable results in the treatment of influenza, rheumatoid arthritis, neuritis, sciatica and other conditions. The composition of Transkutan is secret. The method of using Transkutan is about as theatrical as the method of its exploitation. The patient gets into a hot bath and the entire contents of a $5 bottle of Transkutan is poured on the surface of the water. Since examination of Transkutan in the American Medical Association Chemical Laboratory shows that the preparation is essentially a mixture of turpentine and a concentrated solution of calcium and magnesium chlorides, a thin film of turpentine covers the surface of the bath. When the patient is taken from the bath the film of turpentine will cover the body. He is then wrapped in a blanket without drying or rubbing, placed in a bed, and allowed to sweat. It is obvious that the so-called Transkutan treatment is, for all intents and purposes, nothing but a theatrical variant of a turpentine stupe. (*Jour. A.M.A.*, June 9, 1928, p. 1889).

Ovaltine.—According to the manufacturer, Ovaltine "is a concentration of the nutritive constituents of malt, milk and eggs, flavored with cocoa." In other words, the product is essentially a chocolate-flavored malted milk to which has been added a small amount of dried egg substance. The company gives the following chemical composition of Ovaltine: "Protein, 14.2 per cent; Fat, 8.01 per cent; Carbohydrates, 67.9 per cent; Ash, 3.76 per cent; Organic Phosphorus, 1.18 per cent." According to the manufacturers this "new pick-up drink from Switzerland" originated in Berne over thirty years ago. Two heaping teaspoonfuls of Ovaltine would produce about 50 calories. A glass of milk has an energy value of 170 calories. The power of inducing sleep, which is stressed in the advertising, is similar to that of other warm drinks taken just before retiring. (*Jour. A.M.A.*, June 16, 1928, p. 1968).

Metrazol ("Cardiazol"). — In a preliminary report the Council on Pharmacy and Chemistry states that under the name "Cardiazol" a German product has been marketed by E. Bilhuber, Inc., New York, with the claim that it has actions similar to camphor as "An emergency Stimulant and Regulatory Agent for the Heart." The Council reports that the name "Cardiazol" was found unacceptable because it is therapeutically suggestive, but that the name Metrazol—a contraction of the chemical name, pentamethylentetrazol—would be considered acceptable. An experienced worker in this field who investigated "Cardiazol" for the Council found that the product was a very uncertain respiratory stimulant in conditions of depressed respiration in which carbon dioxide, epinephrine and ephedrine were markedly effective. The Council reports that the pharmacologic studies and clinical trials carried out by this investigator do not give warrant to the enthusiastic recommendations which are found in the published literature and that there is no really satisfactory or conclusive evidence that the substance is an effective and useful stimulant of the mammalian heart. The Council postponed definite action on the product to await confirmatory evidence. (*Jour. A.M.A.*, June 23, 1928, p. 2019).

Iodine Compounds and the Thyroid.—Experiments have been made recently to determine quantitatively the rates at which the hyperplastic thyroid gland of the dog selectively absorbs various iodine compounds. From this study it may be concluded that in practice iodide iodine is of chief pharmacologic significance in altering thyroid secretion. There appears to be little experimental basis for the use of free iodine, even if loosely linked with iodides, as in compound solution of iodine, in the treatment of patients with various types of goiter. (*Jour. A.M.A.*, June 23, 1928, p. 2024).

Liver Extract No. 343.—The Council publishes a report of the Commitee on Pernicious Anemia of the Harvard Medical School on Liver Extract No. 343. The report outlines the work of the committee in developing a potent liver extract for use in pernicious anemia and the studies carried out with the product of Eli Lilly and Co. which was eventually accepted for New and Nonofficial Remedies and placed on the market. Subsequently the committee found that certain lots of this product were weaker than the product manufactured for five months previously. Eli Lilly and Co. collaborated with the committee by withdrawing so far as possible this material from distribution. Recent tests have demonstrated that material of standard strength has again been produced and the committee believes that Eli Lilly and Co. can now recommence distribution of the standard product on a commercial scale. (*Jour. A.M.A.*, June 30, 1928, p. 2102).

Oxo-ate and Oxo-ate "B" Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that "Oxo-ate" and "Oxo-ate 'B'" are the names under which the Smith, Kline & French Co. markets its brands of ammonium orthoidoxybenzoate and calcium orthoiodoxybenzoate, respectively. The Council found that the therapeutic claims contained in the advertising for these products are in general in harmony with the discussion of actions and uses of the iodoxybenzoates in New and Nonofficial Remedies. The American Medical Association Chemical Laboratory examined specimens of these products and, while it found "Oxo-ate" to have essentially the composition required for amiodoxyl benzoate—N. R. R., it found "Oxo-ate 'B'" to be a basic salt containing an excess of calcium. Since the Smith, Kline & French Co. is not the discoverer of either of ammonium orthoiodoxybenzoate or of calcium orthoiodoxybenzoate, and since a non-proprietary name has already been adopted for the former, the Council found "Oxo-ate" and "Oxo-ate 'B'" unacceptable for New and Nonofficial Remedies because they are marketed under proprietary, uninforming names the use of which leads to confusion and thus is detrimental to rational therapy (*Jour. A. M. A.*, June 30, 1928, p. 2103).

The Danger of Irradiated Ergosterol.—The experiments of Windaus, Hess and others established the fact that vitamin D is created in ergosterol by exposure to ultraviolet rays. Irradiated ergosterol preparations have been placed on the market but none have been accepted by the Council on Pharmacy and Chemistry. They are offered for use in the prevention of rickets, tetany and osteomalacia, as well as for other real or fancied powers assumed to be associated with vitamin D. Steenbock's researches on the irradiation of foods have shown the possibilities of securing the rickets-preventing factor by the dietary route and manufacturers of foods and the associated advertising agencies now plan to increase the salable qualities of articles of diet with claims for the vitamine D created in the food products. Some pediatricians have viewed with alarm the possibility that too much vitamin D will thus become available to the public in its diet. That the alarm is not without foundation is indicated by a review of researches just completed in Germany, showing that overdoses of vitamin D may have serious effects. A warning is warranted against too great exposure to ultraviolet rays, against too great an

intake of vitamin D, A, B or any other vitamins. The public sale and widespread use of such products should await careful clinical tests under controlled conditions. (*Jour. A.M.A.*, June 30, 1928, p. 2105).

ABSTRACTS

CHEMICAL TESTS ON BLOOD

The question often arises as to just how active a part the general practitioner should take in the application of the results of our knowledge of the chemical reactions of the blood to his patients. Reed Rockwood, Baltimore (*Jour. A. M. A.*, July 21, 1928), feels that he should be thoroughly conversant with the indications for ordering the tests in various diseases and with the interpretation of the results which are reported from the laboratory as applied to his particular patient but should not take any part whatever in the actual carrying out of the proceedures. The indications for chemical tests of the blood and their interpretation are as follows: I. Never ask for both nonprotein nitrogen and urea tests in the same patient. 2. Except in emergency, never ask for a nonprotein nitrogen determination when the excretion of phenolsulphonphthalein is normal. Determine the output of phenolsulphonphthalein first. 3. Never ask for the creatinine value of the blood unless the nonprotein nitrogen content is above 60 mg. per hundred cubic centimeters. Then determine the concentration of creatinine as a matter of routine. 4. Order determinations of the uric acid content in cases only of gout or suspected gout. 5. Order blood sugar determinations in cases only of diabetes or suspected diabetes or hypoglycemia. 6. Ask for a test of the carbon dioxide combining power of plasma in: (a) Diabetic patients with diacetic acid in the urine. (*b*) Uremic patients with nitrogen retention and dyspnea. (*c*) Patients showing toxic symptoms who are receiving large doses of alkali. (*d*) Conditions associated with disturbed motility of the gastro-intestinal tract with marked toxemia. (*e*) Tetany of all types. 7. Order chloride, nonprotein nitrogen and carbon dioxide combining power determinations in all cases of disturbance of gastro-intestinal motility with marked toxemia. 8. Ask for serum bilirubin or icterus index tests in cases of jaundice, but do not pay too much attention to borderland values. 9. Ask for blood calcium determinations in cases only of tetany of unknown origin. 10. Order inorganic phosphorus tests, if practicable, in cases only of rickets and infantile tetany.

TULAREMIA: REPORT OF CASE IN FLORIDA

S. G. HOLLINGSWORTH, Bradenton, Fla. (*Journal A. M. A.*, July 21, 1928), reports a case of tularemia. The patient thinks that a bone penetrated the right thumb while he was cleaning rabbits either on December 20 or 26. December 29, there was no redness of the thumb, only a rather innocent looking lesion which appeared nearly healed. December 31, the patient had a chill, a temperature of 102 F., a pulse rate of 72 and general aching. The pharynx was slightly red. The lesion on the thumb was apparently not causing the disturbance. January 2, lymphangitis over the radius and inner surface of the upper arm occurred, with three small red nodes in the course of the lymphatics and pain in the axilla. The lesion on the thumb now began to show redness and pustules. When the loose skin over the pustules was removed, the small cupped shaped lesion mentioned by other observers was seen. The small gland in the axilla could now be palpated. The report on the blood serum taken January 15, and sent to the Hygienic Laboratory, Washington, D. C., was as follows: "The serum was found to agglutinate *Bacterium tularense* in all dilutions to 1:320." Treatment consisted of wet dressings of acriflavine applied to the thumb. No internal treatment was given except for symptomatic relief.

RAPID METHOD FOR REMOVAL OF PLASTER-OF-PARIS CASTS

DAVID H. SHELLING and MORRIS D. COHEEN, New York (*Journal A. M. A.*, July 21, 1928), describe a rapid method for the removal of plaster-of-paris casts. With an ordinary cast knife, a superficial cut is made on the cast as a marker. A 25 per cent solution of sodium or potassium citrate is dropped from a dropping bottle along the outline pattern. The cast is softened at once and is then cut with an ordinary scalpel or cast knife. The advantages of this method are: 1. The ease and rapidity with which a cast may be removed. 2. The elimination of elaborate cast-cutting instruments. 3. The ease and rapidity with which fenestras of any size or shape may be cut. 4. Its inexpensiveness. 5. The absence of chemical injury to patients or instruments.

GROWTH-PRODUCING EFFECTS OF EXTRACTS OF TOBACCO ON MICE

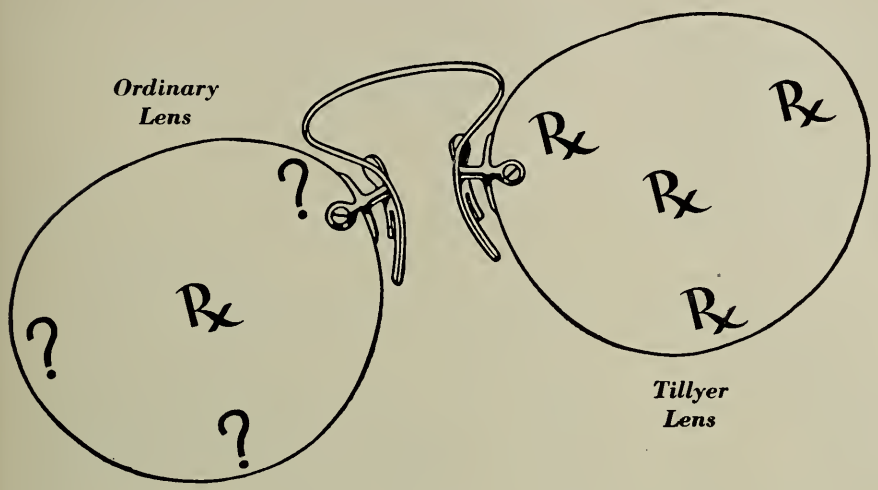
Ferdinand C. Helwig, Kansas City, Kan. (*Journal A. M. A.*, July 21, 1928), makes a study of the growth-producing effects of extracts of tobacco on mice. He believes that tobacco tar obtained at temperatures produced by smoking pipes does not seem to contain any carcinogenic factory capable of producing limitless growth of epithelium in mice. It causes extensive ulceration, which heals on removal of the irritant. Combustion products of tobacco distilled over at temperatures between 400 and 500 C. apparently act similarly to those found in pipe smoking. Tobacco tar when mixed with olive oil seems to possess a factor that will cause atypical epithelial proliferation; but the growth is limited and disappears by spontaneous involution.

CLINICAL OBSERVATIONS ON USE OF INTRAVENOUS DIGITALIS PREPARATIONS

In the clinical observations on the use of intravenous digitalis preparations made by Harold E. B. Pardee, New York (*Journal A. M. A.*, July 21, 1928), patients were selected who had not previously been treated by digitalis or who had not received any for more than two weeks. The patient was kept in bed and the heart rate was counted by stethoscope. Three or four counts during the five minutes before administration of the drug were averaged to obtain the control rate, and frequent counts were made after the administration. Only three liquid preparations have been tested in this way, and each dose was 1 minim of the solution per pound of body weight, so that from 90 to 180 minims (from six to twelve ampules of 1 cc. each) were given to different patients. The only precaution observed was for one to inject the solution slowly, taking thirty or forty-five seconds to complete the injection so that it would mix well with the blood and not arrive at the heart in great concentration. In most cases the patients were in distress from dyspnea, and sometimes also they were troubled by palpitation; these symptoms uniformly improved when the heart rate fell to 80 or 90 a minute. Dyspnea did not always disappear but was much relieved. Two patients were unusually resistant to the action of the drug. Two patients showed an initial fall in rate but with unusual resistance to the later slowing effect. All of the others showed the usual sharp drop in rate in from fifteen to thirty minutes and a further drop by the second or third hour. Experiments have also been made to determine how promptly the typical effect on the T wave of the electrocardiogram makes its appearance after similar doses of the intravenous preparations. It is plain that the intravenous injection gives a prompter effect on the heart rate of auricular fibrillation than does the oral or rectal administration of analogous or even larger doses. There is not much difference as far as the speed of their activity is

(Continued on Adv. page xx)

to
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ABSTRACTS

(Continued from page 358)

concerned between the three intravenous preparations of digitalis. Possibly strophanthin may be slightly quicker in action than any of them, but this is not certain. It seems fair to consider that the appearance and degree of the slowing of the heart rate after these various methods of dosage is a guide to the rate at which the digitalis takes effect on the heart. The dosage should be regulated by the patient's normal weight and by the amount of digitalis which he has taken during the previous two weeks. Great caution is necessary in giving full doses of digitalis to patients who are critically ill. It should never be given as here recommended unless the physician is present before each dose to determine that there are no toxic effects from the previous doses. Slowing of the heart is of course a well recognized toxic effect of digitalis, but it is not so well realized that acceleration of the heart or the onset of irregular heart action may also be a toxic digitalis effect. When a patient who has recently been receiving digitalis is found to be in a condition demanding intravenous therapy, the problem of dosage is extremely difficult. There is no way of telling how much of the full therapeutic dose of digitalis is active within the patient. The author discusses the relative value of the intravenous, the intramuscular and the hypodermic methods of administration. It is obvious that by the intravenous method the drug reaches the blood stream immediately. When the circulation is normal, the absorption of an intramuscular injection will be delayed only for a minute or so, but the more the circulation is impaired, the more slowly will an intramuscular injection be absorbed. This delay is even greater after hypodermic injections, so that the more need there is to obtain an effect, the more one should strive to give the drug by the intravenous route.

Banking Methods

Many a depositor who has lost his money because of improper management of bank officials, will be in position to appreciate Ole's view in the story.

Ole, the night porter, was testifying before the jury after the big bank robbery.

"You say," thundered the attorney, "that at midnight you were cleaning out the office and eight masked men brushed past you and went on into the vault room with revolvers drawn?"

"Yah," said Ole.

"And a moment later a terrific explosion blew the vault door off and the same men went out past you carrying currency and bonds?"

"Yah," said Ole.

"Well, what did you do then?"

"Aye put down my mop."

"Yes, but then what did you do?"

"Vell, Aye say to myself: 'Dis bane queer way to run a bank.'"

A negro mammy had a family of well-behaved boys. One day her mistress asked: "Sally, how do you raise your boys so well?"

"Ah raise dem wid a barrel stave, and Ah raises 'em frequently."

Request for Speed

Robert, aged six, ardently desired a sister, and was told that if he prayed for one a baby might come. So he added to his nightly prayers petition for a little sister.

Results not coming as soon as he wished, one night he added:

"If you have a baby almost finished don't wait to put in her tonsils or appendix, as they usually have to be cut out, anyhow."—*Kablegram.*

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ORIGINAL ARTICLES

THE EPIDEMIOLOGY OF TYPHOID FEVER IN INDIANA

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It may surprise the profession to learn that while we have made great progress in the prevention and treatment of typhoid fever we are still lagging behind neighboring states in this respect. Indiana has the highest typhoid fever death rate of any northern state.

Among the seventy-eight American cities with a population of 100,000 or over there is but one Indiana city, Indianapolis, and it stands in the

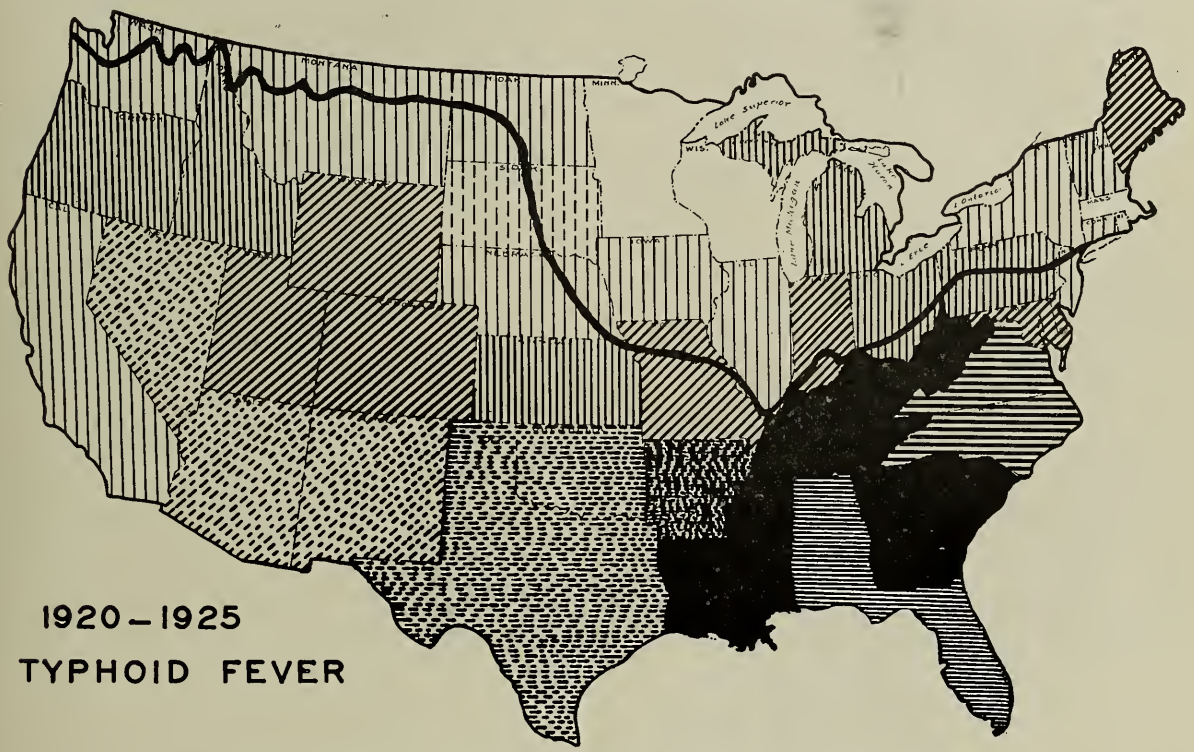


Fig. 1. Map of the United States Showing Typhoid Fever Death Rates.

The regions of highest incidence are the Cumberland Mountain region and the Southern States as a group. The mountain area is, of course, very backward in its development while the southern states have not only the problem of the negro, but very difficult sanitary problems as well. Both regions are rural, and both have very few foreigners.

Of particular interest is the relation of the incidence of this disease to the glaciated portion of the United States. The black line on the map shows the southern limit of maximum glaciation. Note that every one of the lighter states (except California) lies at least in part of the glaciated region and every one of the darker states lies in the non-glaciated portion. The fact that Indiana is as dark as it is is probably due to the fact that the line of the southern limit of glaciation has a large notch in southern Indiana. In this notch lie practically all the Indiana counties with excessively high rates.

Legend explaining the map:

White	0- 30% of Indiana rate for same period (8.7)
	0-2.6 actual rate
Light Vertical Ruling	30-55%
	2.6-4.8
Heavier Vertical Ruling	55-80%
	4.8-7.0
Diagonal Ruling	80-120%
	7.0-10.6
Lighter Horizontal Ruling	120-160%
	10.6-13.9
Heavy Horizontal Ruling	160-200%
	13.9-17.4
Solid Black	Above 200%
	Above 17.4
Broken Lines	No data—Estimations.

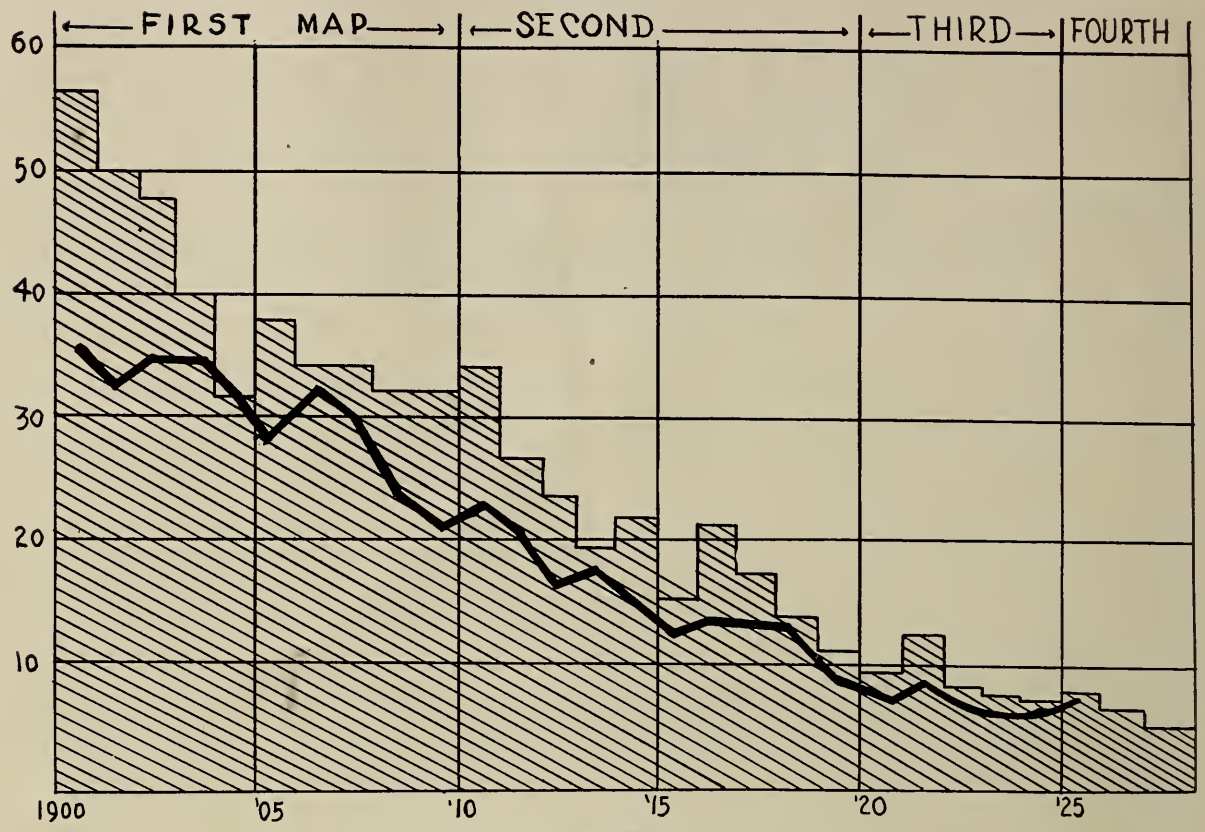


Fig. 2—Typhoid Fever Death Rates—Indiana
Solid Line—Typhoid Death Rates U. S. Reg. Area.

sixty-fourth place according to an analysis of typhoid death rates made by the American Medical Association on basis of the figures for 1926. This is an inexcusable and an intolerable condition. The Indianapolis rate (5.4) is almost exactly twice that of the average for this group of cities (2.77). As compared with other cities of 100,000 population or over in various parts of the United States it has a higher rate than any city in the New England group, any city in the Middle Atlantic states, any in the other North Central states, any city (except Spokane) in the Mountain and Pacific states, and any city (except Atlanta and Jacksonville) in the South Atlantic states. In regard to its typhoid rate it is listed with the second class cities in which group are only two other northern cities—Spokane and Buffalo—both of which have a lower average over a period of years than Indianapolis.

In every year except 1904 during the present century the typhoid rate for Indiana has been considerably higher than the average for the United States Registration Area. In recent years it has not been much above that rate, but when we remember that the Registration Area has admitted, during that time, most of the southern states with their very high rates there is little ground for satisfaction in the fact that we are nearly coming up to average standards.

Such being the facts, it is high time that we are seeking to determine and remove the causes for this shameful condition. The present paper is such an attempt.

The attention is first directed to the maps (Figs. 3, 4, 5 and 6) which graphically show the death rates by counties. Data furnished by the records of the Indiana State Board of Health and compiled by Mr. J. C. Brown were utilized. The rates for the various counties were averaged for the first decade, 1900-1909 inclusive; for the second decade, 1910-1919; for the first half of the third decade, 1920-1924, and finally for the last three years, 1925-1927. The last two periods were made shorter for the reason that we wished to put emphasis upon the progress of the more recent periods. We understand, of course, that the limit of error is rather large when so short a period as three years, and so small a population as a single county is concerned, but if the reader will regard the maps as a whole rather than follow the record of a single county he will find much in the maps that is instructive.

We wish to point out that these first maps are on a relative scale. The progress that has been made in reducing actual rates is very striking and is shown in Figures 9 and 10, near the end of this article. Figures 3 to 6 are shaded in terms of percentage of the state average for the same period. For example a county that has less than fifty per cent of the state average for the period is white, another which has more than one hundred fifty per cent of the state average is solid black, a county with about the average rate is shaded with heavy diagonal lines, etc. The depth of the shading is a rough indication of the

amount of typhoid. More accurate data are given in the legends with the maps.

Even a superficial study of the maps will show that typhoid has had a remarkably uniform distribution during these years. There must be a

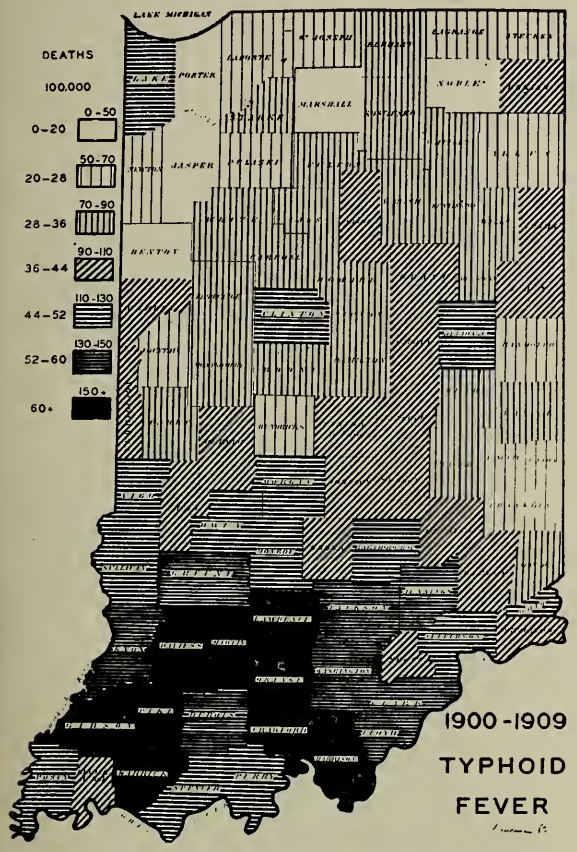


Fig. 3. Typhoid Fever Death Rates in Indiana 1900-1909.

The shading of this and the following three maps is determined by the relative rate which is expressed in terms of the percentage of state average for the same period. The percentage rate is given above the shaded areas, while the absolute rate is given at the left.

Note: The development of the Calumet district (Lake county) had only begun at this time. The typhoid rate is high but not excessively so. A map made on the basis of the 1900-1902 rates shows that at that time the amount of typhoid in that county was near the state average. Clinton county is darker than the surrounding counties and may be the beginning of a focus shown to the north and east in the following maps.

The heavily shaded portion of the state in the south almost exactly corresponds to the strictly non-glaciated area of the state, while the somewhat less heavily shaded surrounding counties almost exactly correspond to the limits of the glacier known as the Illinoian which did not go far south. Compare dark area with the non-glaciated area as shown in map, Fig. 7.

reason why this strictly germ disease is so much more prevalent in certain sections. Evidently the germ has the same characteristics in the northern as in the southern counties. It is quite likely that if there is any difference in the susceptibility of the populations of the two portions a larger percentage of the people of the southern states are immune to the disease than in the northern for the good reason that they have been more exposed to it. The first two epidemiological factors, i. e., 1. The virulent germ, and 2. the susceptible host, can then very promptly be dismissed from consideration as a cause for the peculiar distribution. The remaining factor, external conditions—the "Z" factor of Pettenkofer — presents the most hopeful prospect for the solution of the problem. It is true that these external influences act for the most part either by offering the germ a vehicle, or by affecting the resistance or susceptibility of the host, but even so they are most conveniently considered as separate phenomena.

The Water Supply. The source of the water supply immediately suggests itself as a factor to be investigated. During the earlier part of the century water was considered to be almost the sole method of transmission of the germ of typhoid. In recent years, however, great progress has been made in the improvement of wells and city water supplies, and as a result but two epidemics of any consequence have lately been traced to this source. There were the particularly disastrous epidemics in Fort Wayne (1924) and at Winola Lake (1925), and each case was definitely traced to an illegal cross connection between a good water supply and a grossly contaminated one not intended for drinking purposes. The

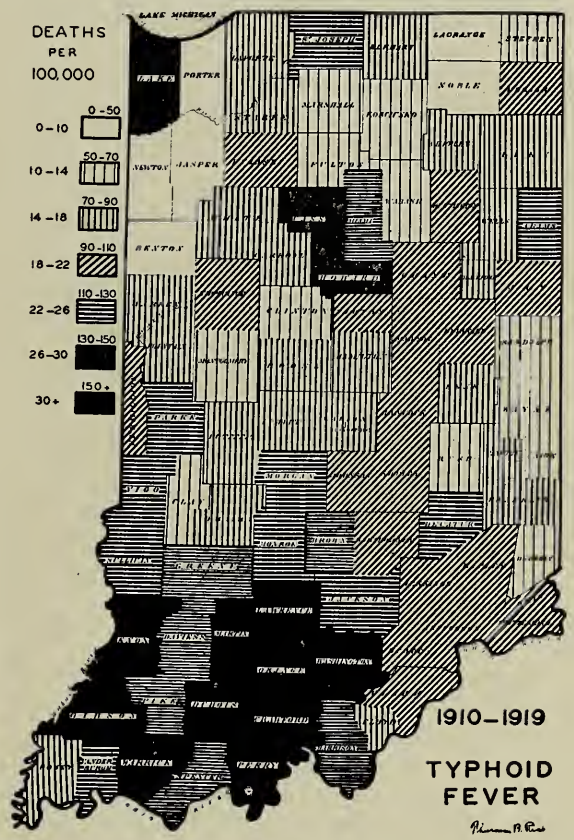


Fig. 4. The Typhoid Fever Death Rate in Indiana, 1910-1919.

The characteristics of this map are very much like those of the preceding. Note that Lake county is now black, due doubtless to the fact that the Calumet district has rapidly developed, and has got ahead of its sanitary safeguards. Cass, Howard and Miami counties form a definite focus but a study of the actual rates shows that this is not due to an actual increase in the rates, but rather to the inability of these counties to keep up with the surrounding counties and the state in general, the average for the state for this decade being approximately half that for the preceding decade. Adams county has relatively increased—possibly a prediction of the focus shown in this region in the next map. St. Joseph county has shown a rapid increase relatively, but will rapidly fall in succeeding maps.

The relation to the glaciated region is approximately the same.

It is important to remember that in comparing these maps we are comparing relative rather than actual rates. Miami county has, for example, shown an absolute decrease though it shows a marked relative increase as compared with the other counties.

matter of cross connections will be discussed in some detail later.

The reason for the heavy incidence in certain southern counties probably is to be found in the fact that the underlying geology, the physiography, the topography, and the economic geography affect the ability of the inhabitants to get good water, and arrange other conditions conducive to health. As one looks at the map he thinks at once of the limestone region as being the part of the state most involved. It has long been understood that where the limestone crops out there is difficulty, in the first place, in making a well that will hold water. Limestone is readily soluble in water containing soil and atmospheric acids, and as a result fissures develop allowing the water to leak out. Limestone is, of course, stratified and the seams between the strata allow leakage. Worse even than this is the fact that the water may come from a great distance through these fissures without being filtered as it would be if it passed through a sandy or loamy soil. Underground streams may flow for miles through caves, and as the water is cold and protected from the action of sunlight plant and animal life conditions are ideal for the transportation for great distances of typhoid bearing filth. A privy contaminating the ground water may endanger the health of people using a well miles away.

As one looks at a map showing the limestone region he is not struck by its similarity to the typhoid maps, however. The area where the limestone outcrops is triangular in shape, extends much further north, and is much more narrow than the typhoid region. Furthermore there is the outcropping of limestone along many of the rivers—particularly the Wabash—and yet the counties along this river are among the lowest in typhoid rates. To be sure limestone underlies all of the state of Indiana, and in many areas it is near enough to the surface to be reached by wells, but if there is a considerable layer of loamy, sandy, or gravely soil above the layer it may be an excellent source of water. The role of limestone, *per se,* in the causation of typhoid has probably been much exaggerated. The determining factor is whether the limestone layers are protected from contamination or not.

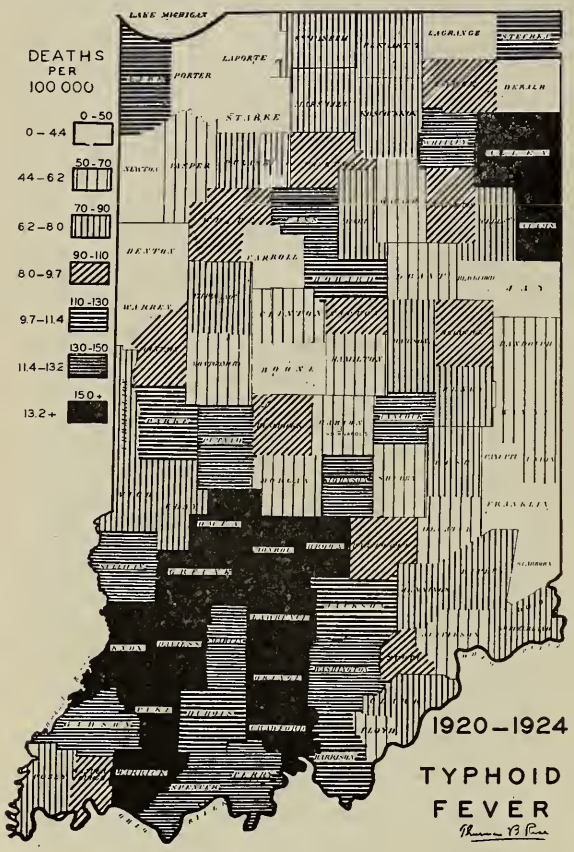


Fig. 5. Typhoid Fever Death Rates in Indiana, 1920-1924.

Lake county has improved. Cass and Howard counties still have more than the surrounding counties. Putnam county is dark because of the epidemic at the State Penal farm. Allen is black due to the epidemic at Fort Wayne traced to a cross connection in the water supply.

This map is for a five-year period and so not so uniform as have been the others. One large local epidemic can make a county black for the entire period shown.

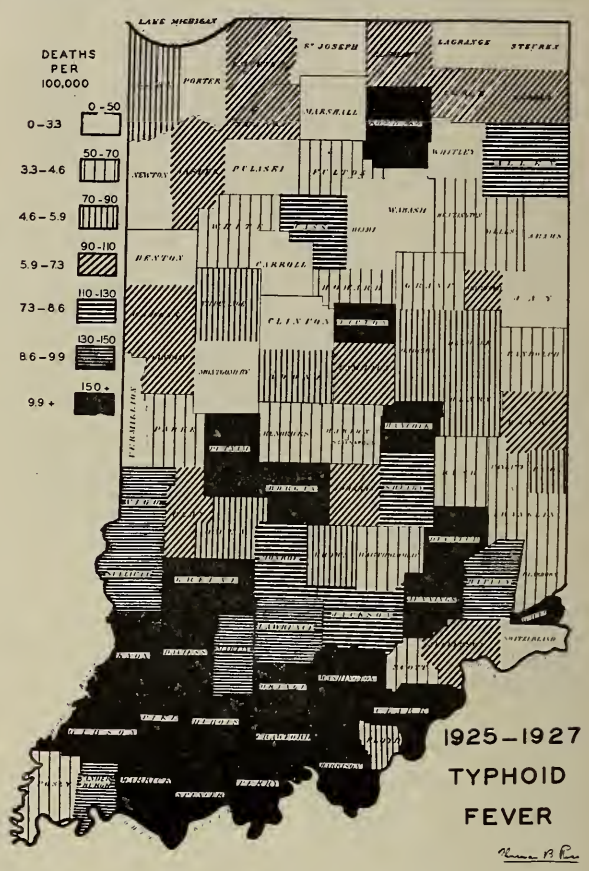


Fig. 6. Typhoid Fever Death Rates for Indiana 1925-1927.

This is a three-year map and therefore somewhat spotty. Lake county is still further improved having now less than the state average but still more than the surrounding counties. Kosciusko is black because of the great epidemic of 1925 traced to a cross connection in the water supply. Hancock is black due to the Greenfield epidemic; Putnam due to the epidemic at the State Penal farm. In a general way the situation is relatively improving in the north and getting relatively worse in the south. Note that Benton county has been white is all maps, and that the surrounding counties except Lake have been much below the state average throughout. Benton county also has very favorable rates for most of the other transmissable diseases.

The non-glaciated portion of the state is consistently black in all maps.

Apparently the two great glaciers which have in prehistoric times spread over most of the state have played a most significant role in determining whether the limestone layers have been adequately protected or not. It may seem strange that a given man in southern Indiana will or will not have typhoid depending upon the whims of the forces of nature acting thousands of years ago, but such are the intricacies of modern epidemiology. The non-glaciated portion of the

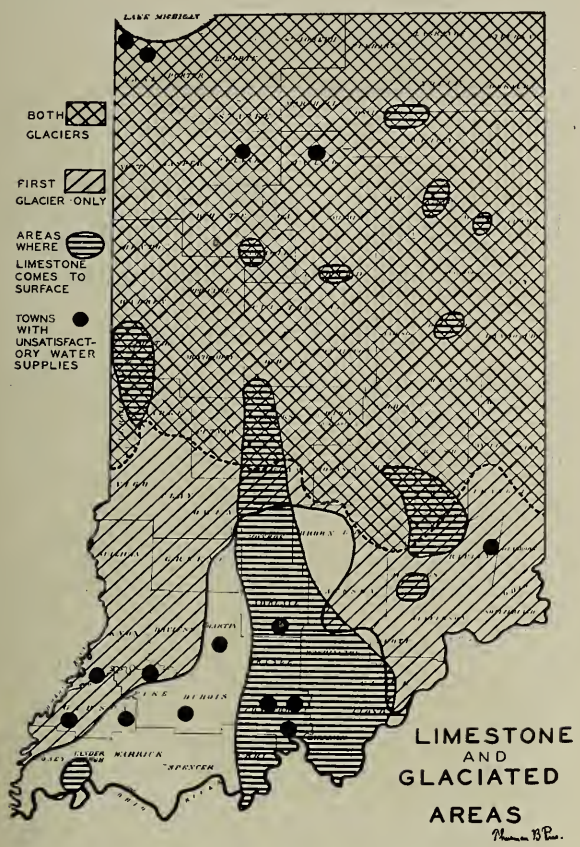


Fig. 7. Limestone and Glaciated Areas of Indiana.

Recognition is given for the information in this map to Handbook of Indiana Geology—Glaciated Area; Visher's Economic Geography of Indiana—Limestone; Indiana State Board of Health—Location of unsatisfactory water supplies.

state as shown by the accompanying map rather closely corresponds to the typhoid region which has so consistently been black in all of the maps. The glaciers ground up enormous quantities of stone into sand and gravel and even finer particles. This material was carried for great distances and deposited in beds and layers. These beds make excellent filters for the ground water, the germs being soon separated out allowing the pure water to go through, and making good wells possible. The comparative absence of an effective filtering medium in the non-glaciated regions is very probably a most important factor. In most parts of the state gravel layers are sought when wells are being dug or drilled. On Figure 1 a heavy line has been drawn along the southern limit of maximum glaciation. It will be seen that all the white states are in this area, and that it skirts the black and dark states. If it were not for the deep non-glaciated notch in southern Indiana our state probably would have a typhoid rate comparable to that of other northern states.

The run-off of the water after rains is, of course, very rapid in these hilly southern counties, and particularly so where the land is cultivated. The soil is mostly clay, which, being relatively impervious, does not serve well as a medium for retaining the water. Wells are hard to get and quite expensive. They are not very satisfactory when they are made. Cistern water is mostly used in many parts, and is, of course, quite satisfactory from a sanitary standpoint, but cisterns are rather expensive, and a great many people are forced to use spring water which is quite unsafe in this district.

Most of the cities of the southern portion of the state must get their water from a river. Such water is perfectly safe if properly filtered and treated, but efficient purification plants are expensive and many cities cannot afford them. Figure 7 shows the location of cities and towns with unsatisfactory water supplies according to the Water and Sewage Laboratory of the Indiana State Board of Health. It will be noted that most of these cities are in the part of the state under discussion. Sewage disposal is also an expensive matter except as it is possible to turn the sewage into the streams directly, thereby creating a menace to communities below.

The matter of cross connections between sanitary water supplies and supplies not intended for drinking deserves special consideration in view of the fact that they have been the cause of two particularly disastrous epidemics in the northern part of the state where epidemics of typhoid are rare. The one at Fort Wayne was due to the fact that a supply intended for technical purposes and belonging to the Pennsylvania railroad was found to be connected with the city water supply of the adjoining city. The impure supply maintained a pressure considerably higher than the sanitary, and a leaking valve allowed the grossly contaminated river water to soil the water of a certain section of the city. There were about fifty cases traced directly to this.

At Winona Lake in 1925 a cross connection between a very impure supply intended to be used only for flushing toilets was found connected with the sanitary system. A certain line-pipe meter was found to have a negative reading of 132,000 gallons, indicating that at least that amount of the impure water had gone into the mains. This happened at the time that a great religious convention was in session with many thousands of visitors from every state in the Union. Hundreds of people had a severe diarrhea, and great numbers went to their homes and came down with typhoid fever. It was impossible to secure the number of cases accurately, but the State Board of Health and the United

States Public Health Service put their estimates at one thousand cases and one hundred deaths. Considering the fact that so many new foci of the disease were created over such wide areas it is not unlikely that this is the most disastrous epidemic which has occurred in the United States, at least in recent years.

Cross connections have been illegal in Indiana for several years. There are still probably a considerable number of them in the various water systems of the state, but they are being rapidly discovered and disconnected. The quality of domestic water supplies has greatly improved during the last quarter of a century, and it is quite likely that the major portion of the decrease in typhoid has been due to this improvement. The public has been convinced that pure water is a necessity, and as a result householders are insisting upon driven wells and cities willing to tax themselves to get supplies that are not merely passably safe but definitely so.

Milk as a Means of Typhoid Transmission. All recent epidemics of typhoid in Indiana, except the two just described, have been traced to milk. Milk is, of course, an excellent culture medium for the typhoid bacillus, and in case it is in the least contaminated with this germ, and then allowed to remain warm for a few hours the particular contaminated bottle becomes a teeming culture. The germ usually gets into the milk from the handling of a careless carrier, from the bottle or the containers having been rinsed or washed with contaminated water, or from flies having soiled the milk or the vessels with material from an adjoining case or privy. Obviously the methods to be emphasized for preventing milk borne typhoid are scrupulous care in the handling of milk and its containers, adequate and prompt cooling, and most important of all efficient pasteurization. There is now a state law requiring that all milk sold must be either pasteurized or from tuberculin tested cows handled in the most cleanly manner. In addition to this it is now being recommended by leading pediatricians that all milk to be given to babies shall be boiled.

The Indiana State Board of Health is at present conducting a survey of the dairies of the state. A traveling laboratory is being sent about spending a week at a place. This survey has not been working long enough for valuable reports to be available. A large portion of the northern and central parts of the state have large dairy farms well equipped. They furnish milk to the various adjoining cities and to Chicago. These larger cities have rather rigid requirements and as a result the milk of these regions is pretty good. In the portion of the state in the south where typhoid is high such is not the case, and we may well believe that dairying is in many communities on a very primitive level. This may be a rather important supplementary reason for the high incidence in these counties.

It is quite important that the characteristics of a water borne epidemic be distinguished sharply from those of a milk borne. Such an understanding will often enable the health officer to detect the source of the trouble in the early days of an epidemic.

Water Borne

1. Usually occur during the time of the year when the water is cold or at least cool.
2. Usually rather evenly distributed among the users of the water supply.
3. Men, women, and children about evenly affected.
4. Cases are inclined to be typical, and with a considerable number of complications and sequellae.
5. The epidemic is usually explosive, rising rapidly to a crest and then falling rapidly (primary cases).
6. The source of the pollution is usually close at hand.
7. All classes of homes using the supply are invaded.
8. Rarely is there more than one primary case in a given family at a given time except when the water is very grossly contaminated.

Milk Borne.

1. Usually occur during the hot months.
2. Usually follows a single milk route.
3. Children mostly affected; women more than men.
4. Cases inclined to be mild, or if not mild to have a very short incubation period and be speedily fatal. There are usually few complications.
5. Epidemic usually drawn out.
6. Source may be at a great distance if milk comes from widely distributed sources.
7. As a rule the best homes are worst hit because the members drink more milk.
8. Frequently several members of the family come down simultaneously having used the same bad sample. It is only in those who use milk.

Flies. Flies can carry typhoid only when there is a carrier or a case in the immediate neighborhood, and even then only when the fly has access to excrement and subsequently to the food of susceptible persons. Flies, stables and garbage cans which breed flies, and open privies are unmitigated evils without an excuse for their existence, but it is rather unlikely that they cause more than a few secondary cases of typhoid.

Carriers. A considerable proportion of those who have the disease remain carriers. Obviously then one of the best methods of preventing carriers is by preventing cases. The next most effective method is by detecting them by stool examinations of all persons upon whom suspicion may rest, and especially of all patients before they are released from quarantine. The carrier is not very dangerous provided he does not handle the food of others, or deposit his excrement where it

can contaminate food, water or milk. There is no reliable method of curing the condition, though several methods may be tried with little promise of success.

Fingers, unwashed vegetables, oysters, ice, and other possible vehicles need not be discussed since this is meant as a statistical study for the most part.

Vaccination as a means of preventing typhoid surely needs no emphasis. The chief objection lies in the fact that it causes the person taking it to suffer rather severely, and as a result the inoculations are much dreaded. The next greatly needed improvement in the method of immunization is a means of detoxifying the vaccine, or of giving it so that it will not be so severe. There is considerable promise that such a consummation may not be far in the future. It is probably true that a larger percentage of the people in the northern counties are vaccinated than in the southern though there is no way of being sure of this.

There are a number of other possible factors which may affect the distribution of typhoid in Indiana.

The Weather. The southern third of the state has on the average a slightly higher precipitation of rainfall (5-10 inches), but this difference could not conceivably be the determining factor. This difference is more than compensated by the fact that the run-off is very rapid, and the clay and stony soil do not hold the water well. As a matter of fact the southern third is much more subject to drought than the northern, but again there is not enough difference to be of importance.

The weather is warmer by about six degrees F. and the growing season longer by about twenty to thirty days, but both of these factors affect other parts of the southern area, as the east portion and also Posey county which have comparatively low rates.

The Soil. The underlying soil was formerly considered to be of the utmost importance in the determination of the filth borne disease. Soil and soil water contamination undoubtedly play a definite role in the transmission of typhoid in their relation to the matter of obtaining a wholesome water supply as has been discussed.

The soil, however, acts in quite a different but no less effective way. The wealth of a rural community, and to a large extent of the adjacent cities, depends upon the ability of the soil to raise crops. The typhoid area is mostly made up of very poor farms; crops are meager; much of the ground has been allowed to grow up in brush. As a result the people of the region are less able to improve their farms, dig wells, build cisterns, provide sanitary privies or septic tanks; houses are less liable to be fly proof, and many of the essential sanitary advantages cannot be had. The cities and towns in such communities suffer for the same reason since they must depend upon the surrounding farms for the most part. Such cities cannot afford a sanitary water supply and a sewage system. Very few such communities have hospitals and as a result cases cannot be hospitalized as all cases of typhoid really should be for the sake of the surrounding community.

Educational Advantages. Typhoid fever prevention is in large measure a matter of education. A map—not reproduced here—giving the distribution of students in institutions of higher learning shows that nearly all of the counties with high typhoid rates have a low rate of college and university attendance. Another map shows that the counties which receive the largest amounts of state aid for schools are these same counties. It is fair then to assume that the common and high schools of that part of the state are not so good as those of places where the tax levy is more liberal. The roads for this section are poor for the most part; there is one automobile to seven or eight persons, while the northern counties have one automobile to about three or four persons. As a result these people mingle less with the outside. This would seem to protect them from the transient carrier, but it also prevents them from adopting modern ideas as rapidly as do the inhabitants of communities where transportation is easy.

Race. The portions of the state where the typhoid rate is high shows no relation to the portions where the negro and foreign population is high. We know from a study of rates on basis of color that the colored portion of the population is

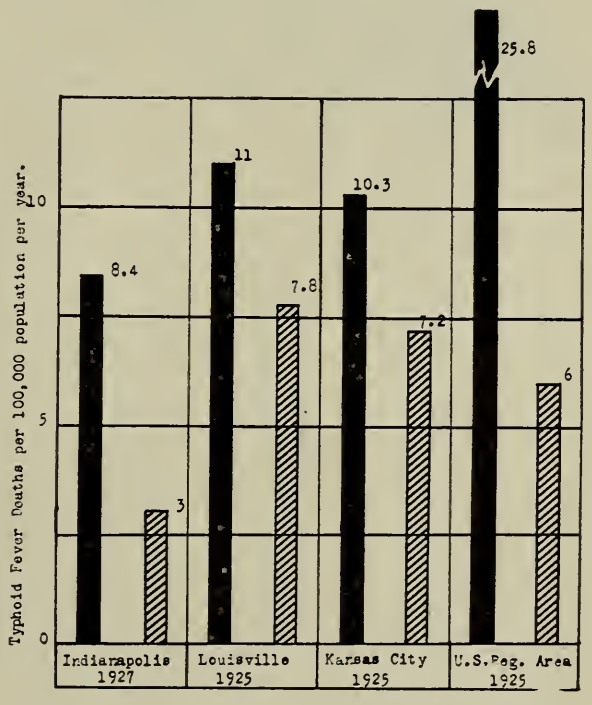


Fig. 8. Comparative Typhoid Fever Death Rates.

Black Negro Race
Shaded White Race

The colored race has a much higher rate than the white race, at least in cities of this general region.

particularly subject to the ravages of typhoid, but since there are few colored or foreign inhabitants in these counties we must conclude that the problem is one for the white stock to solve. Inasmuch as typhoid is becoming rather predominantly rural the influence of the negro's increased susceptibility is lost because this race is mostly urban in Indiana.

Typhoid a Rural Problem. At one time typhoid was a city problem. The water, sewage, garbage, food and milk, flies, and other similar sanitary

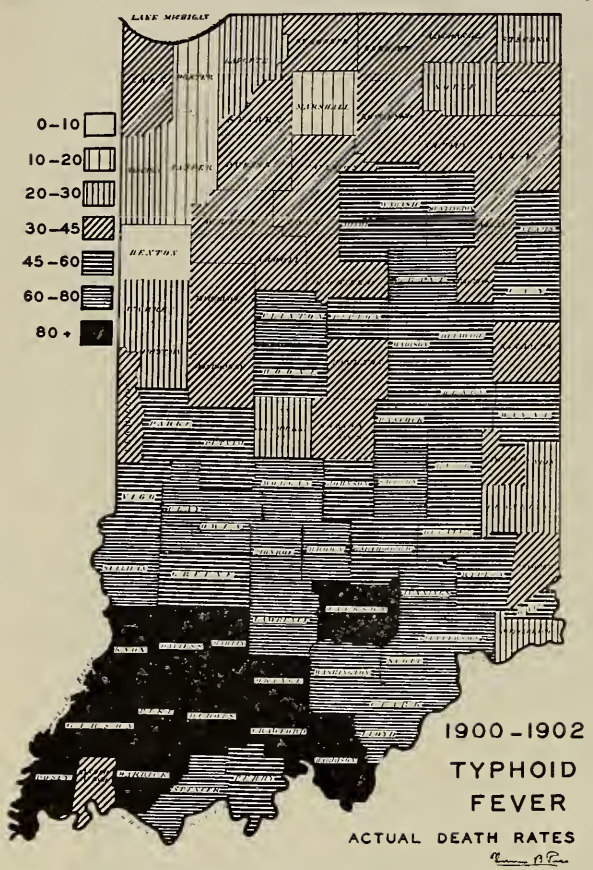


Fig. 9. Actual Typhoid Death Rates in Indiana 1900-1902. This map is made for comparison with the last three years shown in Fig. 10.

difficulties developed rapidly when families lived close together and still depended upon primitive methods of sanitation. The very urgency of the situation forced the cities to act and they have moved forward very rapidly until now certain cities of over 100,000 population frequently go through an entire year without a death. The rural communities have made no such gain though of course conditions are much improved. The problem in the rural districts is far more diffuse, being spread over square miles rather than city blocks, and there is much less wealth with which to make the various sanitary developments. Few rural communities have pasteurized milk, sewers, disposal of wastes in such a way as to avoid flies, a scientifically controlled and tested water supply, and other such advantages.

Density of population and the proximity to much traveled highways do not seem to bear any relation to the incidence of typhoid, or if they do at all it is in a direction opposite to that which would be expected. The thickly populated portions seem to have less typhoid because of this fact if there is any difference. Such regions have more wealth, are more urban, and have more opportunities for education, and these advantages far more than make up for the increased number of contacts.

Comparison of Actual Death Rates. A study of the maps made on a relative basis might lead one to believe that we had not made much progress in the conquest of typhoid. For this reason the actual rates for the first three years of the period under investigation are compared with those of the last three years. The data are placed on the maps according to exactly the same scale. The two maps show a really amazing difference considering that the time interval between them is only a quarter of a century.

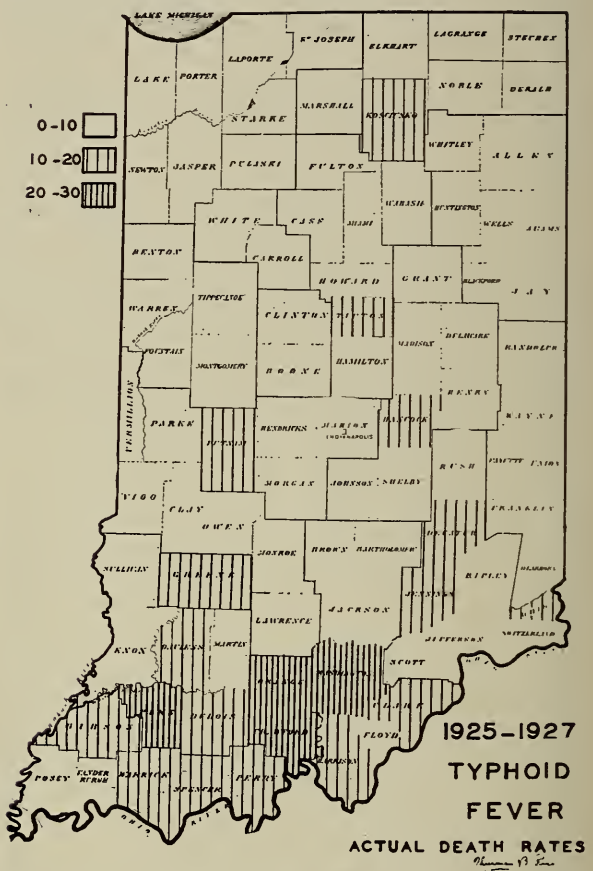


Fig. 10. Actual Typhoid Fever Death Rates in Indiana, 1925-1927.

This map is shaded on exactly the same scale as the preceding map. It shows that an amazing absolute gain has been made.

The Typhoid Fever Death Rates in Indiana. Figure 2 shows the actual numbers representing the various years since 1900, but such curves tend to flatten out near the base line to such an extent that it seems that no or little progress has been made in recent years. For the purpose of showing the *trend* of a disease it is better to plot the logarithm of the rate, or what amounts to the same thing, and is simpler, plot the actual rate on

logarithmetically ruled paper as has been done in Figure 11.

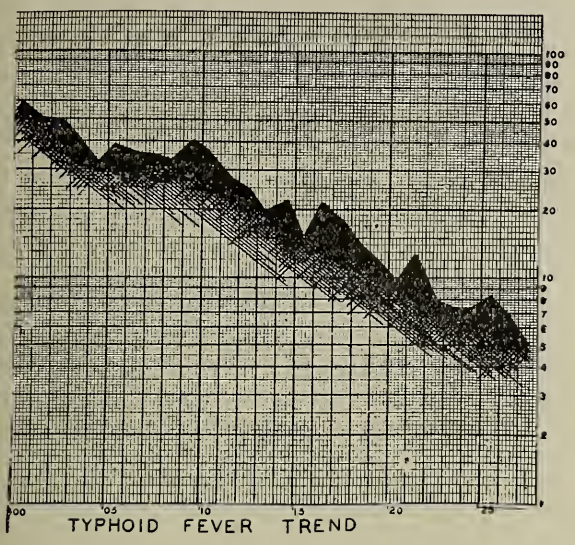


Fig. 11. The trend of the Typhoid Fever Death Rate in Indiana.

This map is intended to show the trend of the Indiana rate and is therefore put on logarithm paper. In 1900 the state was struggling with the task of lowering the rate from sixty to fifty. At present it is trying to lower it from six to five. Obviously the latter problem is just as big a one relatively as the former. On logarithm paper the interval between sixty and fifty is the same as that between six and five, and so a graph of this sort gives due credit to work that is being done recently when the graph is approaching the base line. Note that the trend has its waves and its valleys at rather regular intervals, and that the trend downward has been more rapid since about 1910. We are making progress, but not so rapidly as are the surrounding northern states.

CONCLUSION

1. Great progress has been made since 1900 in the eradication of typhoid fever in Indiana.

2. Indiana has, however, not progressed as rapidly as have other northern states.

3. Certain counties in the south central and southwestern part of the state are chiefly responsible for our high rate.

4. These counties have a particularly hard problem in that they are in a non-glaciated portion, are poor in wealth, and with one or two exceptions decreasing in population.

5. The basic reason for the peculiar distribution of this disease in Indiana seems to lie in the geology and geography of the state.

UNDULANT FEVER IN INDIANA

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This disease has long been recognized as malta fever and was invariably associated with goats and the Mediterranean area of the Old World. It was known to be caused by the Brucella melitensis discovered in 1887 by Colonel Bruce. This organism caused contagious abortion among the herds of goats and malta fever in persons consuming raw milk from the infected goats. In 1897 Bang discovered the etiological agent of bovine contagious abortion and it has since been known as Bang's bacillus. In 1918 Evans, of the U. S. P. H. S., observed the close relationship between Bang's bacillus and Br. melitensis. The two organisms can be distinguished certainly only by agglutinin-absorption, a time consuming and highly technical laboratory procedure. The two organisms are as closely related as are the various types of meningococcus. Bruce's organism causes contagious abortion in goats and malta fever in man, and Bang's organism causes contagious abortion in cattle. The next logical thought was, is Bang's bacillus pathological for man and might it be transmitted to man from cattle by the drinking of infected milk?

In 1923 a pregnant heifer was inoculated intravenously with a culture from a human case of malta fever and the heifer aborted forty-three days later at five and one-half months. The same strain was recovered from feotal membranes as was used to infect the heifer.

In January, 1924, Keefer reported the first human case of undulant fever definitely proven to be infected with Br. melitensis var. abortus.

In February, 1927, Evans reported twenty cases of undulant fever in humans definitely proven to be due to abortus with others probably of that origin. December, 1927, Orr and Huddleson reported sixteen cases from Michigan. New York state now has thirty-five cases. In fact in most states, where it has been looked for, it has been found.

In January, 1927, the Indiana State Board of Health laboratory began running all bloods sent in for Widal tests against melitensis as well as typhoid and in only three weeks picked up a case at Valparaiso, Indiana. This was the case of a boy eighteen years old attending school there. He was taken sick with a fever and indefinite symptoms of toxemia. Blood was sent for Widal test and was found negative for typhoid and positive for melitensis in dilution of 1:640. The patient ran a fever up to 105 and recovered after one month's illness early in February, 1927, and remained well until December, 1927, when last heard from, at which time his blood agglutinated melitensis in dilution of 1:270 and was proven by King of Mt. McGregor Sanitorium to be Br. melitensis var. abortus by agglutinin absorption. The patient drank large amounts of raw milk but we were unable to get blood from the herds supplying the milk.

In June, 1928, Sensenich and Giordano reported seven cases in and around South Bend, Indiana, all in persons using raw milk from herds infected with contagious abortion.

During the spring of 1928, some seventeen cases of undulant fever were found at Richmond all using raw milk from an infected herd.

One case was found in our laboratory from Michigan City.

In July, 1928, Dr. Rhamy, of Fort Wayne, picked up two cases of undulant fever. One case had been drinking raw milk from an infected

dairy over a period of three years. Just prior to taking sick the patient had doubled his consumption of milk. Was this a coincidence or did he overstep his resistance with the increase of milk in his diet? The second case has not been finally worked out at date of writing.

Each case has manifested itself by the indefinite symptoms of a prolonged toxemia and in certain instances were at first suspected of being typhoid fever or influenza. Without a blood examination they would probably have been diagnosed as such. There is nothing in the symptoms of the cases to distinguish them from atypical cases of typhoid fever, influenza, malaria or rheumatism. Contagious abortion is very prevalent in this state, variously estimated at between 75 per cent and 90 per cent of herds. There is a large percentage of milk used throughout the state in its raw state It is inconceivable that the above cases are all that have occurred in the state in the past two years. Most of the cases have been found because the laboratory involved was looking for that particular infection. If all laboratories throughout the state and all the physicians were looking for this infection and examining blood from all prolonged fevers of doubtful origin, we would in all probability have several hundreds of cases instead of some thirty as we now have. The State Board of Health laboratory and most of the other laboratories doing diagnostic work are either equipped or can easily be equipped to test for melitensis. The test is only a simple agglutination test similar to the Widal for typhoid fever. The physician should take blood as for a Wassermann then there will be sufficient serum for agglutination against typhoid, both para typhoids and melitensis. Only one strain of melitensis need be used and the bovine variety is less virulent for man than the others and good antigens are found in certain strains of that type. Killed antigen can be used instead of living antigen thus eliminating the danger to the technician. It is unnecessary to do more than the simple agglutionation tests, for these together with the clinical and epidemiological findings will establish the diagnosis. Blood cultures and agglutinin absorption are refinements which are time consuming and unnecessary for ordinary routine work.

All cases of prolonged fever such as typhoid, especially winter typhoid, influenza and certainly those diagnosed as malaria or typho-malaria in this state should be examined for blood agglutinins against melitensis. Cases of human abortion due to other than deliberate attempts at foetuscide should likewise be tested.

There is some controversy regarding the titre necessary for diagnosis. Any titre, however low, should be investigated and used, as all laboratory tests ought to be used, together with the clinical findings to make a diagnosis. Undulant fever in man tends to be chronic with remissions. It appears to be rarely fatal but often causes long periods of invalidism and deserves the utmost respect from the medical profession. The physician owes it to every patient with a chronic indefinite febrile disease that he consider the possibility of undulant fever.

Undulant fever is one of our communicable diseases and like many others is easily preventable. It is spread by drinking infected cow's milk in the raw state. Park says that the organism of contagious abortion is killed by fifteen minutes' exposure to a temperature of 140 degrees F. so pasteurization of milk is the remedy.

After its experience last year with undulant fever, South Bend changed its milk ordinance requiring the pasteurization of all milk used in the city. Richmond, Indiana, has done likewise and Fort Wayne will no doubt fall in line. There have been to date enough cases found to demonstrate the existence of this infection in human beings in this state in a degree which establishes this disease as a major problem in public health. We believe that the only reason we have but thirty cases is that others have not been recognized. Local boards of health would do well to appreciate the danger always present in their raw milk supplies and adopt preventive measures at once by requiring the pasteurization of all milk rather than wait until their people contract this infection. Physicians of Indiana, who still persist in prescribing raw milk in their feeding cases would do well to consider the danger to which they are exposing their patients by so doing. Why this is ever done is beyond understanding for modern scientific baby feeding calls, invariably, for pasteurized milk. Even certified milk is not free from the danger of contamination with the germs of undulant fever as many cases already have been traced to the drinking of raw certified milk.

The above has been written only for the purpose of bringing the salient points of this problem to the attention of Indiana physicians. Those who wish to study the problem in detail may do so by reading Hygienic Laboratory Bulletin No. 148, "Studies on Brucella Melitensis" by Alice C. Evans, which may be obtained from the Superintendent of Documents, Government Printing Office, Washington, D. C. In the back of this bulletin will be found a very complete bibliography of most of the original work. As for more recent articles, their number is legion and are found in all the medical journals.

OSTEOMYELITIS

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Osteomyelitis, or inflammation of the medullary portion of the bone, may be due either to the pyogenic organisms, or to the tubercle bacillus, or in rare instances to a protozoan organism (Fisher). The two latter have a very definite

and distinct clinical picture and will be excluded from the discussion. Ely states that primary periostitis is but rarely found, that all inflammatory conditions of the bone begin in the medullary cavity, and the periosteum is involved only later. Therefore, all cases of periostitis should be considered as osteomyelitis. This applies even to syphilis where the periosteum alone seems to be affected as shown by the x-ray. Although seen in adult life osteomyelitis is most frequently found in the early period of life (Speed finding eighty per cent before the age of fifteen, and seventy per cent between the ages of eight and fourteen). The lower extremity is affected in from thirty-five per cent to fifty per cent of any series, with the tibia somewhat more frequently involved than the femur. Thornton has called attention to the fact that in involvement of the lower end of the femur the inner posterior portion of the bone is most frequently involved, and therefore the line of approach should be from the inner side of the thigh. The diaphysis is the seat of disease in the vast majority of instances, although an acute epiphysitis is not uncommon, especially in infants. It is more or less characteristic of pyogenic infections of the diaphysis that the disease does not go beyond the epiphyseal line and involve the joint. Three cases of primary osteomyelitis of the patella have been observed by the writer with a very large sequestration of the bone. In none did the knee joint become involved, full function of this joint being maintained. As a rule when the joint becomes purulent the process has extended through the soft tissues rather than through the bone. This selection of the diaphysis and the blocking by the epiphysis may best be explained by the hypothesis of Ely who calls attention to the character of the two portions of the bone, the former being rich in fat and thus of low resistance to infection while the latter (epiphysis) is rich in those cells which are antagonistic to any pyogenic infection.

Osteomyelitis is considered generally as a blood stream infection. Instances have been observed where the infection has been from direct contact with the outside, as in compound fractures or by pressure from adjacent infections as in bone felons. In compound fractures the infection of the bone is usually limited to the region of the fracture line, as the medullary plug blocks the spread into the medullary cavity and the open wound given a fair degree of drainage to relieve the pressure of the pus. The portal of entrance of the organism is not definitely established in all cases. Many are traced to furunculosis, and the question has been raised as to whether the organism of this condition has a specificity for the marrow. Focal infections of all types, middle ear, teeth, tonsils, intestines, have been cited as sources of infection. The relation of trauma to osteomyelitis is one of dispute. Farr states that it is not universally accepted. Others feel that a very close relationship exists. Speed obtained a history of trauma in fifty-five per cent of twenty-one acute cases. Wilensky believes that trauma will produce a subperiosteal hemorrhage with a disturbance in the blood supply to the bone leading to a small sequestration which is later associated with an infecton. [Case, W. M., adult, struck his leg against his desk. An extensive involvement of the femur resulted, leading to a purulent arthritis of the knee. Amputation was necessary to save the life of the patient who was moribund when seen by the writer. At the time of injury he had an extensive furunculosis. The question then arose with the insurance company as to whether osteomyelitis was the result of an accident or of a disease. A compromise was effected in the settlement.]

Osteomyelitis may be divided into two great groups, acute or chronic. Either of these groups may have any of the bacteria as the offending organism and the process may be either diffuse or localized.

The symptoms of an acute osteomyelitis are those of any acute infection. Pain is usually the first symptom and is referred as a rule to the bone affected. However, it is not uncommon to have a general systemic involvement with the pain referred to many joints, thus giving rise to the general picture of an acute inflammatory rheumatism. [Case, C. F., six years old. Admitted to hospital with pain in the left knee. Temperature 102 degrees. No injury. Examination negative. Next day pain in left elbow and right foot. Pain in the left knee not present. The following day pain in the right knee. Examination, including throat and ears, again negative. On the fourth day (ninth day of illness) tenderness found along the right thigh. Temperature 103. Child very ill. X-ray showed suggestive changes in the femur. Exploration of the femur demonstrated frank pus in the medullary cavity, with involvement of almost the entire shaft. Radical operation; complete recovery.] The joints, however, do not have the characteristic redness and exquisite tenderness; there is an absence of the marked sweating, nor does the pain respond to the use of the salicylates. The pain in osteomyelitis is of a severe throbbing type. If the bone is not too deep in the soft tissues, as is the femur, swelling, redness, and tenderness are easily made out, and if drainage is not instituted suppuration follows, with a discharging sinus. In the fulminating types the local signs and symptoms are masked by the marked general pictures of extreme prostration and death rapidly follows.

The diagnosis of the acute type of osteomyelitis must be made upon the history of localized pain, and tenderness, with perhaps swelling and redness, loss of function, fever, and the signs of general systemic infection. The x-ray is of little or no value in the early stages of the disease, as the destructive process in the bone is not sufficiently

advanced to give a shadow change until several days have elapsed, long after the diagnosis should have been made. [Case, J. W., age five years, for several days had complained of pain in the left tibia. History of previous slight injury. At time of examination there was tenderness, swelling, and redness. Two days later fluctuation was noted. X-ray negative for any bone change. At operation an abscess was found in the soft tissues and the periosteum was stripped from the bone. The medullary cavity was opened and frank pus obtained. X-ray two weeks after onset of symptoms showed a destructive process in the medullary cavity.]

The chronic type of osteomyelitis is that of any chronic condition. The systemic symptoms have subsided, and if the sinuses have been formed the temperature drops to a lower degree or becomes normal. The anemia persists and the tenderness remains. Sequestration of the diseased bone, with the formation of an involucrum, follows and the infection will advance until the entire shaft, to each epiphyseal line, has become involved in the necrotic process. In the localized type of osteomyelitis there may be only pain without swelling or other physical signs other than point tenderness (Brodie's abscess). The x-ray is often necessary to confirm the diagnosis. Syphilis always should be excluded in these single bone lesions. It is characteristic of the pyogenic osteomyelitis that unless the disease has been primarily an epiphysitis the neighboring joints are rarely invaded. Cases are seen, however, in which the disease does extend from the diaphysis through the epiphysis, and also where the joint has become involved through a spread of the infection around the epiphysis and through the soft parts. With draining sinuses the chronic osteomyelitis may persist for months or even years without great disturbance to the patient other than the constant dressings and the infrequent acute exacerbations when the drainage is not adequate. Small pieces of bone may be discharged through the sinuses, but the time soon comes when these sinuses become so small that the large masses of dead bone cannot be extruded.

The treatment of acute osteomyelitis is more or less well established. All agree that drainage of the medullary cavity should be obtained at the earliest possible date, long before any change can be noted in the x-ray. It is only in the type of operation for drainage and in the subsequent plan of treatment that there is some difference of opinion. As the dissection is carried down to the bone a marked oedema of the soft parts will be noted, and this is a most important sign of a medullary involvement. [Case, C. H., age six years. Pain in the region of the right hip for four days. Thigh held in flexion and abduction. Motion in hip restricted by pain. Temperature 104 degrees. General toxaemia. X-ray negative. Diagnosis of acute osteomyelitis upper third of femur. At operation as dissection was carried through the soft tissues a marked oedema was noted. This oedema was characterized by shiny bleds of fluid in the fascial planes which are not found in the oedema of circulatory obstruction. The periosteum was intact. Drill hole was made in the femur below trochanter and a thin sandy exudate under pressure obtained. This later gave a culture of staphylococcus aureus. Six drill holes were made and wound packed. Complete recovery without further drainage.] It should be emphasized again that a primary periostitis is rare. Therefore, the presence of pus beneath this sheath of the bone should not lead the operator to feel that the medullary cavity is not involved and should not be investigated. Exposure of the medullary cavity never can do any harm. If pus is not found the wound can be closed without drainage. If pus is found, drainage, of course, is indicated. Drill holes of a medium size should be made through the cortex. As the drill is removed the character of the exudate from the medullary cavity should be carefully noted. If it appears normal and is not under pressure other drill holes should be made, and if no evidence of infection is found the operator may close the wound tightly. If the exudate is thin and of a sandy character and under pressure, or if frank pus is noted, then the case should be considered as one of osteomyelitis. In the early cases many operators are content to make numerous large drill holes and keep the wound open for drainage. Others prefer to open the medullary cavity wide through removal of traps of the cortex, or by even more extensive dissection. The general symptoms of infection are then combatted by appropriate means. If the case is given drainage at a very early date, sequestration may not occur and the case will go on to further recovery without any bone complications. If the destruction is more advanced, then a sequestration will take place and the case is treated later as one of a chronic type. In these early cases complete immobilization of the affected part should be effected by means of a plaster of paris cast. Acute osteomyelitis always should be considered as an emergency condition, and operation done as soon as possible. Not infrequently the cases will develop rapidly a severe septicaemia and death ensue.

The treatment of chronic osteomyelitis is not so well defined as is that of the acute type. That the plan of attack in the past has been unsatisfactory is well shown in the many different types of treatment and in the study of the end results which show long convalescence and repeated or subsequent operations. In general it has been universal to give adequate drainage and not leave any overhanging edges of the cortex. But from this point on the plan of treatment has been most varied. Packing with bismuth paste, zinc chloride and other antiseptic drugs, the use of irrigations with bactericidal solutions, the installation

of Dakin solution, the attempt later to fill the bone defect with bone chips, fat pads, facial strips, and muscle flaps have all had their trial with varied success. In all of these plans daily, or very frequent change of dressings has been a part of the treatment. Attention is called to this point as in contrast to the infrequent dressings of the Orr plan of treatment. None have become specific, none have become orthodox. Each operator has had his own experience with the usual varying results. The merits of these many types of treatment will not be discussed.

Several years ago Orr presented a plan of treatment of chronic osteomyelitis which in many ways was a complete departure from the old teachings. To those who have had the opportunity to give it a trial, the end results have been most gratifying; and to those patients who have had previous operations it has brought a most happy convalescence. To those who have not given it a trial it will perhaps appear unsound surgically and bacteriologically. A committee of the Clinical Orthopedic Club after a year of study of the many different methods recommended the Orr treatment as the most efficient. The Orr plan of treatment has three fundamental factors; good surgery, long intervals between dressings, and immobilization of the operated part. Good surgery has been practiced by many; infrequent dressings by few; and immobilization by almost none. To Orr should be given the credit of combining these three principals in the treatment of osteomyelitis.

The case should be studied carefully to determine the extent of the disease and the location of the sequestra. The parts are prepared as for a clean operation, a tournequet being applied. The approach to the bone should be determined so as to damage the soft parts to the least degree and to give best drainage. The dissection is carried down to the periosteum which is stripped from the cortex. With a sharp, curved chisel the cortex is removed, giving complete exposure of the medullary cavity the entire extent that the latter is diseased. It is important that the sides of the cavity should be smooth and slanting (without any over-hanging edge) and the ends should be beveled so as to make a boat-shaped cavity in the bone. At this point it is well to condemn the use of the currette in bone surgery, especially in osteomyelitis. One certainly would not use a currette in removing a necrotic area of soft tissue where the clean cuts without great traumatism could be made by means of a sharp knife. The same is true in opening the shaft of a long bone. The sharp chisel gives a clean cut edge while the currette leaves a rough traumatized surface. It is essential in opening the medullary cavity that the limits of the necrotic area be reached and that no small pocket of pus be left. This part of the operation is the "good surgery."

When the bone cavity has been prepared the tourniquet should be removed, and if any marked hemorrhage is found it should be controlled with bone wax. This rarely will be necessary. The cavity is then well filled with vaseline gauze which should not be packed too tightly. The surrounding skin should be covered with vaseline, as not infrequently the discharge will be of an irritating character and produce an excoriation of the skin. The writer has been using a vaseline impregnated with charcoal in order to lessen the odor which is later to be found as an objectionable feature. Heavy pads of gauze cover the vaseline dressing. The extremity is then encased in a plaster of paris cast so as to give complete immobilization to the muscles and to the soft parts. This immobilization is most essential and if not included in the treatment the end result may be unsatisfactory. In two of the writer's cases where the humerus was involved this immobilization was not carried out and the cases did not do as well as in other similar cases where casts were used. These casts should be well padded and not applied too tightly.

It is in the subsequent handling of the case that exception usually will be taken. The packing in the bone cavity should not be disturbed for a long period of time, from four to eight weeks. During this period a window may be cut in the cast and the outside dressing be renewed if the drainage is excessive or if the odor becomes too offensive. As a rule the drainage is much less than has been observed in other plans of treatment and not infrequently when the second dressing is made, at the end of seven or eight weeks, the original gauze will be found dry. In other cases the drainage has been more profuse and necessitated a change of the outside gauze every third or fourth day. In many cases, when the cast is removed, the wound will be found well filled with new tissue and the skin completely covering the operated area. In other cases the area will be a mottled one with small areas of granulation tissue separated by bands of new skin. In a few of the cases, even when the cast and original dressing were removed after seven weeks, there will be but little filling in of the operated wound by new tissue. However, even in these cases it will be found that the bone is completely covered with healthy granulations and the convalescence is uneventful although somewhat longer than expected.

The method of treatment described above has two great advantages. First, the percentage of cures without second or subsequent operations is much greater than in any other known plan. In the writer's experience, covering three years of such treatment, only two cases have required a second operation, and one of these was a case in the humerus in which fixation was not used. The experience of Orr and of others who have cases

of longer duration are exceptionally good. Secondly, the doing away with the daily dressings not only relieves the surgeon of a great deal of work, but more important relieves the patient of those pain-dreaded days which were so nerve racking to the patient, to the surgeon, and to the family. The one disadvantage is the odor. This may be combatted by means of the change of the outside dressing or by the use of charcoal vaseline.

The reaction which takes place in the wound during the period of fixation without a change of the inside dressing has not been definitely determined. Orr (personal communication) is inclined to the opinion that perhaps the old humurol hypothesis will best explain the phenomen. Those who have been interested in the problems of the bacteriaphage reaction consider that this bacteria reaction accounts for the rapid cleaning up of the infection and the healing of the defect. The writer feels that there is considerable merit in this explanation of the healing process, and some studies are being conducted along this line.

In conclusion it should be emphasized again that complete fixation of the part is equally important as are the factors of thorough surgery and infrequent dressings. The following cases which are from the service of the James Whitcomb Riley Hospital for Children are illustrative of the end results of the Orr plan of treatment of chronic osteomyelitis.

Case M. J. (Ri. 2393), white, age fifteen months, admitted April 14, 1926. Nine weeks ago fell downstairs, seven weeks ago had boils, five weeks ago had abscess on buttocks, three weeks ago pain in left leg. Leg lanced and pus obtained. Operation April 17. Partial sequestrectomy. Frequent dressings. Reoperation May 28. Readmitted October 20. Third operation October 27, at which time sequestrectomy was done, wound packed with vaseline gauze and cast applied. First dressing removed December 2. At that time wound almost entirely closed. New cast and vaseline dressing. This removed at end of three weeks. Frequent dressings made for superficial wound until May 20, 1927, at which time patient discharged as well. No recurrence.

Case H. B. (Ri. 3863), white, seven years. Admitted August 3, 1926. Humerus became painful in September, 1925, and lanced in October, 1925. Has had a discharging sinus ever since. Operation August 12, 1926, sequestrectomy, daily dressings. Second operation September 7. Third operation September 2, 1927, daily dressings. Fourth operation October 24, 1927, sequestrectomy, vaseline gauze, cast. Wound completely healed November 23, 1927.

Case R. T. (Ri. 2022), white, age five years. Admitted August 8, 1926. Osteomyelitis began in tibia December, 1925. Operated two weeks later. Not healed. Operation August 24, 1926, sequestrectomy, vaseline gauze, cast. First dressing removed six weeks later. Discharged as healed October 10, 1926. No recurrence.

Case C. A. (Ri. 3978), white, age ten years. Osteomyelitis left tibia. Admitted February 17, 1927. Entire shaft of tibia involved. Operation two days later, sequestrectomy, vaseline gauze, cast. First dressing removed March 12. On account of discharging sinus from the lower end of the tibia at epiphyseal line, second operation August 24, 1927. Sequestration, vaseline gauze, cast. First dressing removed seven weeks later. Frequent dressing for superficial wound. Discharged as cured January 21, 1928.

Case R. M., (Ri. 2897), white, age eight. Osteomyelitis of left tibia. Onset December 24, 1926. Operation March 26, 1927, sequestrectomy, wound packed with vaseline gauze and plaster of Paris cast applied. Cast changed at end of three weeks. Dressing changed for first time March 27, at which time wound almost entirely closed. Final dressing made two weeks later. No recurrence.

Case E. B., (Ri. 3010), white, age nine years. Admitted April 23, 1927. Duration of osteomyelitis nine months, left tibia. Operation in November, 1926. On admission had discharging sinuses in left tibia, left humerus. Operation May 1, 1927, sequestrectomy of tibia, vaseline gauze, cast. Operation May 9, 1927, sequestrectomy of humerus, vaseline gauze, cast. First dressings removed June 10. Tibia noted as healed October 1 and humerus noted June 2, 1928, as still having sinuses.

Case G. M. (Ri. 3958), colored, age three years. Admitted April 6, 1927. History of fall seven weeks ago. Fracture (?) of femur. No operation on first admission, "to wait for sequestration." Re-admitted April 23. Operation May 4, sequestration, vaseline gauze, cast. Dressing changed and new cast May 21. Re-operated September 9 on account of draining sinuses. Sequestrectomy, vaseline gauze and cast. This dressing changed November 30. Bone covered with granulations. Superficial wound healed January 25, 1928.

Case R. B., (Ri. 4105), white, age five years. Admitted May 4, 1927. History of injury to left leg October, 1926. Leg swollen, fever for two months. Lanced January 13, 1927. Sequestrectomy February, 1927. Wound packed with vaseline and cast applied. On date of admission tibia found to be healed, but an osteomyelitis had developed in the femur. Operation May 17. At this time two superficial sequestra removed from femur. Daily irrigation. Reoperated June 8, at which time a radical opening of the shaft was done. Wound packed with gauze and cast applied. First dressing removed June 27 at which time "healthy granulations" noted. Cast reapplied. Cast removed August 11, at which time bone entirely covered with granulations.

Frequent dressings for superficial wound until May 21, 1928, when case was discharged as cured.

Case G. H., (Ri. 4620), white, age fifteen years. Admitted June 13, 1927. Began with sudden pain in right femur August, 1923. Operated September, 1923, and July, 1926. On admission deep scars with discharging sinuses on inner side of lower half of femur. Operation September 6, 1927, sequestrectomy, vaseline gauze, cast. Dressing changed and new cast October 29. Second operation February 1, 1928, sequestrectomy, vaseline gauze and cast. First dressing at end of second week. At this time bone found to be covered with granulations. Dressings made every two weeks for superficial wound. June 10, 1928, showed a very deep scar with a narrow strip of unhealed granulation at its bottom. Unable to find exposed bone by probe.

Case E. C., (Ri. 4127), white, age fifteen years. Admitted October 5, 1927. History of inflammatory rheumatism three months ago. Abscess formed in left tibia; lanced. Operation October 8, 1927, sequestrectomy, vaseline gauze, cast. First dressing made at end of six weeks. Bone covered with granuations and only superficial wound left which was dressed every two weeks until March 10, 1928, at which time patient discharged as well.

Case N. B., (Ri. 4618), white, age ten years. Admitted November 17, 1927. History of sudden pain in leg August, 1927. Incised and pus drained. Operation November 24, sequestrectomy, vaseline gauze and cast. First dressing changed and new cast applied January 3, 1928. Case discharged as cured February 22.

Case R. V., white, age 30. Admitted to hospital January 22, 1928. History of chronic osteomyelitis in left tibia for five years. Had had six operations. Operation January 26. Entire shaft of fibula found necrotic. Sequestrectomy, wound packed with vaseline gauze and cast applied. First dressing made at end of ten weeks. Bone entirely covered with granulations. Skin excoriated. Frequent dressings made for superficial wound. Discharged as cured June 1, 1928.

COLON BACILLUS INFECTION OF THE SKIN

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It has been rather a common occurrence in dermatologic practice to have cases referred, suffering from a so-called low-grade infection of the skin, which are refractory to ordinary antiseptic measures.

Recently two such patients were treated by me. They seem to be of interest on account of the nature of the offending agent and the far removed location of the lesions, in respect to the apparent focus of infection.

Case 1: J. A., male, aged fifty years, consulted his family physician four weeks prior to my seeing him, concerning a small infected papule on the dorsal surface of his left hand which refused to heal. After prescribing several antiseptic remedies, including tincture iodine and mercurochrome, the lesion was "burned out" with an electric needle. It did not heal and continued a sluggish course for the next three weeks with marked inflammatory reaction and considerable exudation of creamy, purulent fluid. Finally he was referred to me for treatment. Examination at this time showed a marked inflammatory ulceration on the back of the left hand, 1½ cm. in diameter, bathed with creamy exudate, with ragged, undermined edges. The only significant history as to its probable cause was the fact that the patient had been taking enemas recently to overcome a stubborn costive tendency. Smears from the lesion showed an organism resembling the colon bacillus which was later proven by cultures.

The lesion was dressed daily with hexylresorcinol solution (S. T. 37) and treated with increasing daily doses of quartz-mercury light without much, if any, improvement. He was then given two suberythema doses of x-ray directly over the ulcer, closely shielding the adjacent skin. After the last treatment with x-ray the lesion promptly healed.

Case II: J. R., male, age fifty-five years. This patient consulted his family physician six months prior to my seeing him on account of a small inflammatory papule which had appeared on the back of his right hand followed by a crop of "blood boils." This condition the patient thought due to pitching clover in a dusty field. Two of these so-called "blood boils" were lanced but refused to heal kindly. Just before and during this period he was taking frequent soap suds enemas as relief for indigestion, gas pains, and constipation. His physician told him he probably had a chronic appendicitis.

After many crops of boils there were two lesions which, after apparently healing, would break down again, and these areas persisted. The lower lesion was lanced twice and a small amount of puss evacuated. These two areas gradually spread till each attained the size of a silver dollar.

His family physician finally became discouraged, made a diagnosis of cancer and referred him to me for radium treatment.

Past history—Never had any serious illness except small pox fourteen years ago and then in bed only eight days.

Family history—Father died at seventy-six of pneumonia. Mother died at seventy-three of dropsy. Two brothers died; one of stomach trouble, one of "tuberculosis of brain," after a severe injury to the head. One sister died in infancy; cause unknown. Three sisters living and

well. Three brothers living and well, except one fractured a cervical vertebra, recovered, but still has paralysis of right arm and leg.

Physical examination showed a well developed, poorly nourished, middle-aged male. Heart and lungs negative, abdomen showed nothing abnormal on inspection and palpation. B. P. 140/80. Pulse 78. Temperature 99. Skin showed evidences of prolonged exposure to the elements, being dull red in color, dry and wrinkled, and some suggestion of keratosis on the face and hands. On the back of the right hand was an irregular shaped, roughly circular ulceration with undermined edges about the size of a silver dollar, exhibiting raw surfaces bathed with a purulent secretion. Upon pressure pus was seen to exude from several points from under the apparently normal skin near the edge of the ulceration. Just above this ulcer was another similar lesion though smaller in area, and above this on the forearm was another similar lesion but considerably larger than the first one.

It was decided immediately that a malignant condition did not exist, as there were absolutely no clinical signs of carcinoma. The provisional diagnosis was a low-grade infection of the skin, due to some unknown organism.

A smear was made which showed abundant organisms resembling the colon bacillus which was later proven by cultural methods. An autogenous vaccine was made and injected subcutaneously at appropriate intervals. Sufficient was given to initiate a moderate reaction after each dose.

While giving this vaccine, the ulcers were cleaned, dressed, and dressing kept moist with S. T. 37 and he was treated by weekly exposure of lesions to one-quarter of a suberythema dose of x-ray. Five doses in all were given of x-ray and five doses of autogenous vaccine. At the end of this course of treatment the ulcerations showed but little, if any, improvement.

As the patient was losing weight rapidly, unable to perform his work, and had had no success with various methods of treatment, I suggested his entering the hospital for more radical procedures. He was admitted to the hospital, taken to the operating room, and under local anesthesia by brachial plexus block with novocain, the lesions were denuded with the scalpel, going to some distance into normal skin and they were curretted thoroughly. This surgical work was done by Dr. W. R. Davidson of Evansville. Immediately after bleeding had ceased the areas were exposed to moderate dosage of a Kromayer lamp, then dressed with paraffine gauze and full strength chlorozene. These lesions were so treated daily but dressed with ten per cent chlorozene. Exposure time with the Kromayer lamp was gradually increased.

The wounds remained the same for a few days then gradually filled in and epithelization began at the edges and they rapidly healed with absolutely no signs of infection.

Today, one month after operation, the lesions are healed, with very little if any scar formation. The patient is back to work and he states he has gained thirty pounds in weight.

A review of the literature shows the following: MacWatters,[1] in an article labeled "Vaccine Therapy in General Practice" stated that in bullous onychia which persists and refuses to heal there is usually an added infection of bacillus coli. He also says that chronic ulcer of the leg of indolent type is frequently associated with added infection with bacillus coli. In another paragraph he states: "In all clinical cases of suppuration it may be necessary to find what added infection is keeping up the condition. At times most unexpected organisms are formed in the discharges, bacillus coli, and Friedlanders bacillus, frequently." He claims all such cases heal quickly with sufficient dosage of autogenous vaccine.

Nicholas, Gate and Ravault,[2] report a patient with a rebellious infection of skin of right wrist which was proved to be due to the colon bacillus, and healed under vaccine therapy. Nothing is mentioned in regard to etiology.

Auche',[3] reports a case of multiple intra-dermic abscesses due to the colon bacillus in a nursling. These abscesses were located above the left iliac crest, external surface of right thigh, and left thigh. Simple evacuation of these abscesses lead to quick recovery.

Pusey's text book: "Principles and Practice of Dermatology" devotes three lines to colon bacillus infections:

Potter,[4] described bullous impetigo caused by colon bacillus.

Stelwagon in his text book: "Diseases of Skin," does not mention bacillus coli infections.

COMMENT

1. Any chronic indolent infection showing little tendency to heal under ordinary methods of treatment may be due to the colon bacillus.
2. Smears and cultures should be made from all so-called indolent ulcers to identify the offending organisms.
3. It would seem to be sound advice to instruct patients to thoroughly disinfect the hands after taking douches and enemas.

SUMMARY

1. Two cases of colon bacillus infection of the skin of the hands, forearms, both probably due to contamination from taking enemas.
2. Ulcers in both cases showing no tendency to heal over a long time under ordinary antiseptic treatment.
3. One case healed quickly under x-ray therapy. One case did not respond to x-ray therapy nor autogenous vaccine but healed quickly with surgical measures and quartz mercury light.
4. There is a paucity in the literature regard-

ing colon bacillus infections of the skin yet it is believed to be commoner than supposed.

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CHRONIC ASTHMA

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The term chronic asthma is used in contradistinction to the acute type of cases which are brought on suddenly by the presence of some foreign protein. These acute cases are relieved as soon as the pollen is withdrawn or the patient desensitized.

The chronic asthmatics present an entirely different picture. They give a history of having had asthma for a long period of time, frequently years. At times it is better, generally in warm, dry weather, even though no form of treatment is being used. They are not entirely free from all symptoms but the attacks are milder and when fall comes the attacks are severe.

In my opinion all cases of this chronic type of asthma are bacterial in origin. It may be reflex in character, that is, the focus of infection may be outside of the respiratory tract, such as an infected gall bladder, teeth or appendix. We have all seen cases of asthma disappear after the eradication of a focus of infection.

Chronic bronchitis is nearly always associated with any case of asthma of long duration. It may be that the organisms responsible for the bronchitis is the causative agent of the asthma. That is, the asthma originally was of bacterial origin, the resulting bronchitis being caused by the same organisms and these organisms in turn reproduce the asthma. In other words a vicious circle may be produced.

In a few cases that have come under my observation I was satisfied from the history that in the beginning they were cases due to hypersensitiveness of a foreign protein. In each case a change of environment in the early stage would bring about a cessation of the asthma. On returning to their initial surroundings the asthma again appeared. After several trips away with relief they found that a complete change had no effect on the course of the disease. They noticed that their condition was of a different character. The asthma was more continuous and the accompanying cough was productive of a purulent material instead of frothy. These patients were treated the same as others with chronic asthma and are completely recovered. I believe that these patients acquired an associated bronchitis and that the organisms responsible for this caused the asthma either directly or by their toxins.

Diagnosis. The diagnosis of this type of asthma is made primarily on the history. The main points are: First, the long duration of the illness; second, it is not seasonal; third, it is more or less continuous; fourth, change of environment has no effect on its course; fifth, many patients give a history of the first attack following an acute respiratory infection, such as pneumonia, influenza and bronchitis. Patients suffering with this type of asthma fail to show by skin tests any definite signs of hypersensitiveness.

The differential blood examination in all cases examined showed an increase in the eosinophiles, the percentage varying between five and eleven per cent. I have found in my experience that the degree of eosinophilia and the degree of the asthma are not proportionate.

On physical examination there are the classical findings of a markedly emphysematous chest. There is high pitched breathing. Even though the patient is apparently free from asthma the respiration is labored and jerking.

Treatment. The most successful form of treatment I have found is vaccine therapy, using the pathogen selective method. This method of preparing vaccines was first used by Meyer Solis Cohen and Heist[1] working together. A culture is made from the supposed focus in the patient's own coaguable blood under the supposition that only the pathogenic organisms will grow, there being enough bactericidal power in the blood to inhibit the growth of the saphrophitic organisms. This insures a pure growth of bacteria that are pathogenic.

Technique. A culture is made from the material coughed. I give the patients a sterile container with instructions not to save the first material coughed up so as to insure getting the organisms from deeper in the respiratory tract. With a loop a smear is made on the bottom of test tube and this covered with from eight to twelve cubic centimeters of the patient's blood collected from the vein at the elbow. The amount of blood used depends upon the amount of material in the smear. Naturally too much blood might inhibit the growth of the organisms if they are mildly pathogenic. Likewise, if there is too small amount of blood used, there might not be enough bacteriocidal element in the blood to inhibit the growth of the saphrophetic organisms. Generally I use ten or twelve cubic centimeters. The tube is then placed in the incubator for twenty-four hours, at the end of that time a culture is made on ordinary media from the original blood culture. From this point on the vaccine is prepared in the usual method.

The great advantage of this method is that a pure growth of the organisms that are pathogenic is secured. There is no growth of the numerous saphrophitic bacteria found in ordinary cultures from the sputum. Usually only one organism is found (sometimes two) to be pathogenic.

About a year ago I reported a series of twenty cases in which I used this method of preparing vaccines.[2] Since that report I have used the pathogenic selective method in the treatment of twenty-seven cases of chronic asthma.

Drugs. To my knowledge there is no drug which permanently helps these patients suffering from chronic asthma. Adrenalin, ephedrin, lobelia, potassium iodide and strychnine can all be used to good advantage during the attacks.

Table No. 1 is a composite record of the cases treated with the results obtained.

Number of cases	27
Cured	19
Improved	6
No results	2*

*One patient became dissatisfied after third injection and stopped treatment.

Table No. 2 shows the causative organisms in this series of cases.

Number of cases	27
Pneumococcus	11
Streptococcus	1
Pneumococcus and Streptococcus together	8
Strepto and staphylococci together	6
Influenza baccilus	1

The greatest number of patients noticed improvement between the fifth and eighth injection. In two cases improvement was not noticed until after the tenth. Five cases reported easier breathing and no severe attacks following the third injection.

CONCLUSION

1. Chronic bronchial asthma is a distinct clinical disease.
2. This type of asthma is of infective origin.
3. Vaccine therapy using the Pathogen Selective method is the most successful form of treatment.

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THE URINARY TRACT AND INTRA-ABDOMINAL SYMPTOMS

(CASE REPORTS)

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Much has been said and written in the past decade about obstruction in the ureter as the cause of vague intra-abdominal symptoms. For a time the argument centered chiefly about the term ureteral "stricture" with which the name of Hunner is usually associated. According to his views there is a localized inflammation in the ureteral wall caused by a blood-borne infection from some distant focus in the body, or by direct extension from a neighboring organ—the appendix, the seminal vesicles in the male, and the tubes and ovaries in the female. That the condition can be caused by direct extension was readily admitted; but the metastatic aspect of the disease is still argued, with the majority on the opposing side. As one hears the subject discussed, however, it is interesting to note that, although its method of production is still disputed, its existence is no longer doubted by many who opposed him violently at the start.

How often the urinary tract is overlooked in the consideration of intra-abdominal symptoms is made clear when we observe that in a series of fifty cases reported by Hunner[1] in 1918, thirty-four had been operated previously, and of these twenty-seven were not relieved of their symptoms. Four of the twenty-seven had each had three operations without improvement.

Walther[2], in an article presented before the Urological section of the American Medical Association, in 1922, reported a series of thirteen cases, nine of whom had been operated previously for various complaints, five of them twice, without relief. There are others who report similar experiences. The following is an interesting list of the diagnoses made on patients later reported as cases of ureteral stricture: Pelvic inflammatory disease, ovarian disease, functional disorders of the stomach and intestines, chronic peritonitis, intestinal adhesions, sigmoid adhesions, colitis, chronic pancreatitis, gallstones, appendicitis, lumbo-sacral and ilio-sacral joint pains, neuralgia of the sacral plexus and sciatica.

Stricture of the ureter is not the sole cause of a train of symptoms which is likely to be associated with almost every organ in the abdomen except the one that is responsible. Other obstructions of the ureter, though perhaps less numerous, cause the same confusion, and among these are chiefly small ureteral stones which do not cause complete blocking of the urinary outflow, ureteral kinks due to inflammatory bands and nephroptosis, and obstructions caused from pressure upon the ureter by abnormally placed vessels. Of these ureteral stones give us the least difficulty because with the present popularity of the x-ray this condition is not easily overlooked. In fact, the reverse is true—shadows are often called stones which upon careful investigation are found to be calcified material outside the urinary tract. To determine the presence or absence of the other conditions is not always an easy matter.

It must be remembered that in these conditions the onset is gradual and the obstruction to the urinary flow is not sudden and complete and, therefore, not productive of the characteristic symptoms. To add to our difficulty the patient complains not at all, or only at intervals, of urinary disturbance; and the urine, on examination, contains no abnormal elements such as blood or pus cells. It is for these reasons that our atten-

1. Bulletin, Johns Hopkins Hospital, January, 1918.
2. Walther, H. W., Journal American Medical Association, 79:733, August 26, 1922.

tion is so often directed to some other organ as the source of the trouble. The following case histories illustrate typical cases of the different types of obstructions:

(1) *Ureteral obstruction due to ureteritis (stricture).* Miss S., age twenty-two years, single, a saleswoman, seen in June, 1922. Present trouble started in 1919 with pain in lower abdomen, not localized and not radiating to back except during menstrual time. At this period, too, she had frequency and burning on urination. A physician whom she consulted at this time advised her to have a chronic appendix removed and a "falling womb" corrected. This was done in 1920 but no relief followed. Another physician then gave her vaginal treatments for several months. In 1921 the pains grew gradually worse until at the present time they are colicky in character beginning in the left side and back and go down to the bladder and thigh. Urination not frequent except during menstrual periods, with burning.

General physical examination was negative. There was no vaginal discharge. The uterus was moderately retroverted.

Catheterized urine specimen contained 10-12 pus cells per field, no red blood cells.

Cystoscopic examination revealed a normal bladder and right ureteral orifice. The left orifice was gaping and the ridge prominent giving the impression of the presence of a stone in the intramural portion. A No. 6F catheter, however, passed easily to the kidney pelvis. The urine from this side contained 10 pus cells per miscroscopic field; function was good. Culture from the left side yielded staphylococcus albus. Although no obstruction was met in this patient she was dilated with Nos. 8 and 10 F bulbs on two occasions following this. The urine cleared up completely and her symptoms were gone for the first time in years. She was observed for ten months during which time there was no recurrence.

(2) *Blocking by an aberrant artery in a band of adhesions.* Miss R., age twenty-five, single, bookkeeper. Seen in April, 1926, during an attack of renal colic. History of present illness dates back four years when she began with pains of an indefinite nature in the right side. She does not remember whether the pain was associated with urinary disturbance. Two years later she was cystoscoped and was told there was nothing wrong with her kidney. She was then advised by another physician to have her appendix removed which she had done the same year. Her symptoms remained and later became a constant dull aching in her back (points to loin). A urologic examination in February, 1926, led to the diagnosis of intermittent hydronephrosis due to kink.

Our findings were essentially the same except that we found no kinks or bends in the ureterogram. It was observed, however, that this patient's symptoms were always aggravated when she was in the upright position. This might easily happen when, in the normal excursion of the kidney, the ureter is pressed against some firm band or vessel. We ventured this diagnosis and advised exploration which was done in May, 1926. Our impression was found to be correct and the vessel, one of small caliber, was divided between ligatures. This patient was last seen in May, 1928, and states that she has been entirely free from all symptoms since her operation.

(3) *Kink due to nephroptosis.* Mrs. F. S., age thirty-nine, married, seen in January, 1928, complained of general disturbance in the right side of her abdomen. Symptoms are indefinite, pain is not localized. In the upright position there is an uncomfortable sensation in the right lower quadrant. Seven years ago she had had her uterus and appendix removed for this very condition without any improvement. She thinks the trouble is aggravated lately when doing her work, otherwise there is no marked change. In the course of the examination a flat plate was made of her abdomen which showed a dense kidney-shaped shadow on the right side, the midpoint of which was at the level of the iliac crest. She was, therefore, referred for pyelography. Urine is negative. Function good on both sides. A pyelogram made with the patient recumbent shows the right kidney much lower than usual as compared to the other side and the ureter contained a sharp bend. In the upright position the kidney is fully four inches lower and the ureter bent upon itself sharply three or four times. The pain caused by the injection of the pyelographic medium is described by the patient as identical to the sensations she frequently has. This patient was advised to have a nephropexy and is, in my opinion, a case where one could expect some results from the operation which was in former times very much abused.

Hunner and others advise that diagnosis of ureteral stricture or ureteritis is not dependent upon meeting an obstruction to the advance of the catheter but rather on the grasp or hang encountered by a bulb as it is withdrawn. The principle is the same as in the diagnosis of urethral strictures and I have tried it on numerous occasions in cases of ureteral stricture. Thus far, I frankly admit, I have not been able to demonstrate it and I am beginning to believe that it is impossible to do so unless one is using an open tube through which to catheterize the ureters. My own experience has been that the patient is the best guide. If a stricture is present she will tell you in a very few days whether the procedure was of any help to her. That, after all, is the important thing.

To demonstrate kinks and nephroptosis successfully one must not only resort to stereoscopic plates but one must also be prepared to make views with the patient in any desired position.

To carry this out speedily and with comfort to the patient a modern cystoscopic table is a necessity.

SPECIAL ARTICLE

THE PHYSICIAN'S INVESTMENTS

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Schools and colleges generally have covered practically every active phase of life except the taking care of property and investment of moneys. Very few people give this subject anything but a passing thought. They are not familiar with the different types of investments and they depend wholly on hearsay, or "tips", as they call it, when they have funds they wish to "put out on interest."

Strange it is that a physician who spends five, ten, twenty or more years of his life thoroughly mastering his vocation will enter the investment field with no training whatever. With no knowledge of the science of investing he is willing to place his funds, his savings, without the definite knowledge that they will be safe for his loved ones, or to maintain himself and his dependents during the later years of his life or their lives.

This is not a world of accidents. Great riches are not made from "tips"; we pay for what we receive. A physician should choose his investment banker as he expects a lay person to select his physician, and in selecting the bank or the security house he should consider the "feeling of the community". He should ask himself the question, "Does such a bank or investment house stand well? Is it one in which people have confidence?" After making his choice he should consult the banker and place on him the responsibility of his recommendations.

When you get right down to the facts governing safe investing there are really but four distinct methods.

1. Buying stocks on margin; most dangerous speculation.
2. Buying high grade bonds outright for cash.
3. Buying high grade stocks outright for cash.
4. Buying high grade stocks and bonds outright through installment payments.

The first principle of those who aspire to save their money is to remember that all purchases should be confined to safe securities, and a physician should consider but one form and that is, buy outright.

The investor should eliminate all stocks and bonds paying high rates. He should cast out of consideration any unseasoned securities. In fact he should cast out everything but the best. The best investments include the securities of the United States government, United States municipals, industrial corporations, established railroads, public utility bonds, and stocks and bonds of foreign countries of the highest standing. I wish to repeat that the best is none too good, that five per cent per annum and capital saved is better than ten per cent perhaps and capital lost in the end.

There can be no season for investing, no definite period during the year. The time to buy securities is when you have the funds in hand. Do not wait until banks and corporations are failing and times are panicky. Do not wait until the country is abounding in prosperity, bumper crops are everywhere, large banks, corporations and railroads are having tremendous earnings, and the feeling is in the air that greater prosperity is in store. In either case you may think you will be able to turn around later and sell your securities at a handsome profit. You are not wholly investing for permanent income—you are speculating. The real investor invests when he has the funds, whether the rate is four per cent or seven per cent. The person who buys securities when the prices are high and the return is low, or the prices are low and the return is high, will in the long run average up a fair rate of return and at the same time he will not have any idle funds waiting for what he thinks is going to be the opportune time to buy. Banks, trust companies, insurance companies, in fact all investors of large sums invest their money when they have it, and what is true of the large investors applies to that of the small investors or the individuals.

The only safe method for a physician with $1,000 or $5,000 on hand is to ignore price movements and to invest in the outright purchase of seasoned securities. Whenever he has funds, invest them and make it a policy to do that at regular intervals. If the trained financier cannot tell when security prices are high or low with every means at his elbow—reports, statements, Moodys, Poors and Standard Statistics, it stands to reason that the untrained investor with no means of checking the market is certainly not in position to pass judgment on market conditions.

To boil down the substance of a policy for a physician's investments I would say that he can be reasonably sure of the safety of his money and a fair return on his funds if he will keep in mind three rules:

(1) Buy only seasoned securities;

(2) Buy outright and avoid all margin purchases;

(3) Buy when he has the money and at regular intervals.

This may be ultra-conservative advice, but experience has proven that it is the only royal road to a substantial estate or wealth. For the inexperienced investor to attempt to select safe securities without the aid of some outside honest and

(Continued on page 405)

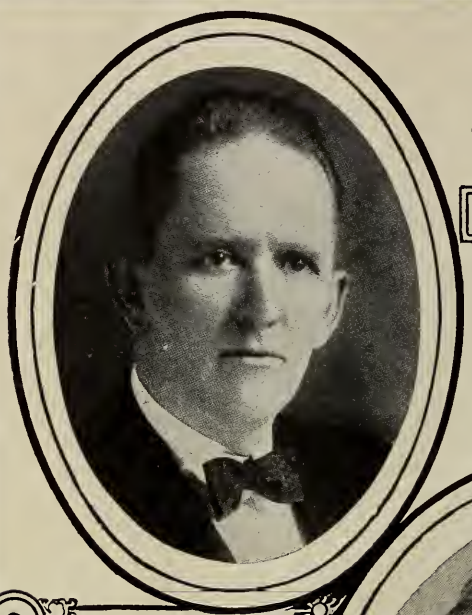


GEORGE R. DANIELS

MARION

President Indiana State Medical Association

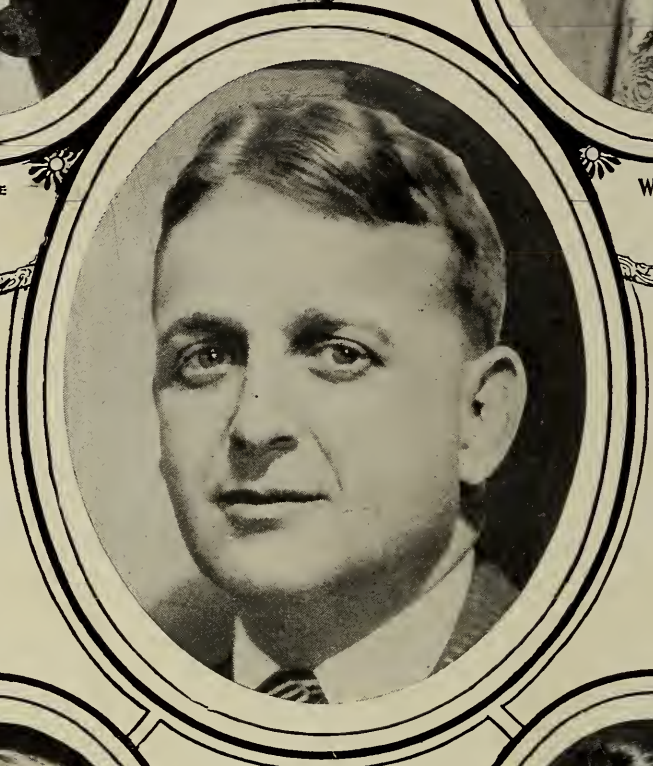
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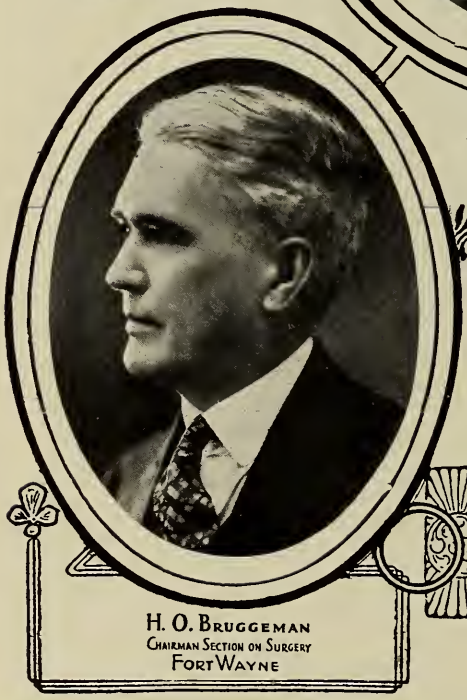
CHAS. E. GILLESPIE
PRESIDENT-ELECT
SEYMOUR



WILLIAM DOEPPERS
TREASURER
INDIANAPOLIS



MR. THOMAS A. HENDRICKS,
EXECUTIVE SECRETARY,
INDIANAPOLIS.



H. O. BRUGGEMAN
CHAIRMAN SECTION ON SURGERY
FORT WAYNE



H. C. KNAPP
CHAIRMAN EAR, EYE, NOSE AND THROAT SECTION
HUNTINGTON



O. T. Scamahorn
Chairman Section on Medicine
Pittsboro



Ernest Rupel
Secretary Section on Surgery
Indianapolis



B. D. Ravdin
Sec. Eye, Ear, Nose and Throat Section
Evansville.



G. M. Cook
Secretary Section on Medicine
Hammond

THE GARY SESSION

The annual session of the Indiana State Medical Association will be held in Gary, Wednesday, Thursday and Friday, September 26, 27 and 28. All of Lake County welcomes you, and the Lake County Medical Society, the second largest in Indiana, invites you to be its guests. Conventions come and conventions go with the years, and every effort is put forth to make each one a little better. This year's session, the seventy-ninth annual session of the Indiana State Medical Association, should be the best in the association's long history because of two things—an unusually fine scientific and entertainment program, and a most unusual convention location in the heart of the northern Indiana industrial district nationally known as "The Workshop of America." Members of the Lake County Medical Society will be joined in welcoming the physicians of Indiana by the 250,000 Hoosiers who live in this district composed of such rapidly growing cities as Hammond, East Chicago, Indiana Harbor, Whiting and Gary, and although Gary happens to be the convention headquarters city it is to be understood this is a Lake County party, and *all of Lake County* welcomes you.



E. M. SHANKLIN
HAMMOND
Chairman, Committee on Arrangements.

The City

Gary, the convention headquarters city, is only twenty-one years of age, and every visitor will be interested in this rapidly growing city which already has a population of almost 110,000 people, a taxable wealth of $150,000,000 and which covers an area of 28.8 square miles. Today the "Steel City" stands as one of the most fascinating communities in America. Gary possesses the world's largest steel mills, and an internationally famous school system. Gary has millions invested in fine new civic and commercial buildings, and is near the wonderland of nature, the famous dunes. Gary has a population representing many nations, but almost half is Hoosier-born. Located at the southern end of Lake Michigan, Gary is on the ancient trails of the Indian tribes. It was here that Father Marquette camped in 1673, and later the spot where Gary now stands was an important halting place on the old Detroit Trail leading to Fort Dearborn, now Chicago. Joe Bailey's Indian trading post, established in 1882, is still to be seen just off Dunes Highway. In 1850 the Michigan Central Railroad was built through to Chicago, and other roads quickly followed. Still, the sand wastes and dunelands at the southern tip of the lake were disregarded. It was not until 1906, after the late Judge Elbert H. Gary of the United States Steel Corporation saw the strategic position of the land and its exceptional rail and water transportation facilities, that a civic and industrial enterprise of consequence was begun. The corporation started construction of new mills in 1906, the population of the village of Gary in its first year being only 334. Mills were built and operations started; more mills were built and more men employed. In the meantime the corporation, through its subsidiary, the Gary Land Company, was building streets and modern homes. The population grew and grew. Today Gary's estimated population is nearly 110,000. The industries in Lake County include the Gary Works, Illinois Steel Company, American Bridge Company, National Tube Company, American Sheet and Tin Plate Company, Universal Portland Cement Company (U. S. Steel subsidiaries), the Union Drawn Steel Company, Gary Screw and Bolt Company, and numerous others. The employees in Gary alone total more than thirty thousand with a payroll of more than sixty million dollars per year. The steel corporation plants occupy a seven-mile stretch along the lake shore and cover more than one thousand acres of land. The twelve blast furnaces have a capacity of 2,700,000 tons of pig iron annually, and other production statistics, too numerous to mention here, are on the same gigantic scale. Gary holds the world's steel production record and is proud of it, but she also is proud of her civic record. Great civic, commercial and fraternal buildings, model homes, fine schools, beautiful churches, parks and playgrounds, modern, well-kept highways, and progressive citizens who make advancement possible.

Those who like to relax at convention time will find Lake County's vacation features especially inviting. There is a fine three-mile stretch of beach at Gary on Lake Michigan with a beautiful $160,000 bath house and $300,000 recreation pavilion. Bathing, boating, fishing, hiking, horse-back riding, golf and other sports await you here. Those who enjoy it will find a hike through the fascinating, shifting dunelands a genuine joy. For those who seek modern comfort and ease, the hotel in which the convention headquarters will be located, the Hotel Gary, is a ten-story palace in the field of modern hostelries. This hotel was

completed and opened last fall. It features a beautiful lobby lounge wainscoted in American walnut, with a mezzanine balcony leading to the Crystal ballroom. The clubrooms of the Gary Commercial Club are located on this mezzanine floor and the doors are thrown open to every member of the Indiana State Medical Association by Captain H. S. Norton, president of the pioneer club since its organization twenty years ago.



Hotel Gary.

The headquarters for the convention and program sessions will be the Hotel Gary. This is Gary's new $2,500,000 hotel which has cooperated in making all convention arrangements, including the maintenance of regular rates during the convention.

The clubrooms include a large lounge with American walnut wainscoting to the ceiling, a library, roomy recreation room, English grill, private dining rooms, and other features all of which are at the disposal of members of the Association during their stay in Gary. The scientific exhibit this year will be housed in two of the rooms of the club, and every member is urged not only to attend the exhibit but to make himself perfectly at home in these club quarters.

Visitors will be interested in the new Gary Gateway, a civic building and park project involving millions, now well under way at the north end of Broadway, Gary's main business street. Here is a million dollar city hall, already completed, while across from it is being built a million dollar court house following the same style of architecture and forming a city "gateway."

Gary's buildings include its City Church (Methodist) a down-town million dollar property having a comprehensive civic-service program; the ten-story million dollar Knights of Columbus building; the new ten-story Gary State Bank building; new half-million dollar Post-Tribune model newspaper plant; Elks Temple; Masonic Temple; Memorial Hall seating nearly five thousand; Moose Temple; Y. M. C. A.; Y. W. C. A.; million dollar Palace Theater, and others. Space does not permit enumerating all details in proof of the statement that Gary will be a most interesting convention city, but you will find proof in abundance starting with your arrival at the fine new Hotel Gary and Gary Commercial clubrooms. Despite its rapid growth, Gary has builded for the future, being one of the few cities in Indiana which has a modern city plan and zoning ordinance. The city has 171 miles of improved streets, and the business district contains forty-two blocks of modern ornamental street

lighting units. It has fifteen banks and trust companies, twenty elementary and high school units, and sixty-three churches. There are five improved municipal parks, and among the business and social organizations of the city are the Gary Commercial Club, the Gary Country Club, the Kiwanis, Lions, Optimists and Rotary clubs, and the Gary Woman's Club. We, who are here waiting to greet you, feel sure that you will return to your homes proud that Lake County is a part of the great Hoosier state.

Robert B. Phillips,
Convention Secretary,
Gary Commercial Club



Gary City Hall

Golf

Gary has two golf courses, one municipal course and the eighteen hole course of the Gary Country Club. The annual tournament of the Indiana State Medical Golf Association will be held at the Gary Country Club, starting at 9 o'clock Wednesday morning, September 26. Trophies will be presented at the smoker the same evening. Those wishing to participate in this tournament should send their names to T. B. Templin, M.D., 579 Broadway, Gary, who will make proper arrangements.

Headquarters

The new Hotel Gary has been selected as headquarters for the Association convention. A corps of assistants will remain at headquarters, where everyone is urged to go at once and register and see about lodging reservations. All information about any phase of the convention activities will be dispensed at the desk marked "Information" on the mezzanine floor, which may be entered from either the lobby or Sixth Avenue.



Gary Gateway and Railway Department.

Lake County Hospitals

The Methodist Hospital of Gary extends a hearty welcome to the visiting members of the Indiana State Medical Association and their friends, and invites inspection. This hospital is located on Sixth Avenue. It is a five story fireproof structure of colonial design. Capacity of the hospital is 100 beds. In 1926 a new nurses'

home was built, containing class rooms, recreation room, lecture hall, etc. The hospital is owned by the Indiana Methodist State Hospital Board and is under their general supervision.

St. Margaret's Hospital, at Hammond, at the meeting last year of the American College of Physicians and Surgeons for the United States and Canada, was awarded second highest honors for its first aid equipment, plan and location of its emergency room.

St. Mary's Mercy Hospital, of Gary, is the pioneer medical institution of Gary. It recently has been enlarged and now has a bed capacity of 235. The addition is modern in equipment and furnishings, with a surgery on the fifth floor finished in Alabama marble and green tile.



Gary Postoffice.

The Lake County Tuberculosis Sanatorium was opened on September 30, 1925, and is located one and one-half miles north of Crown Point. Its capacity is 130 beds. It is for the treatment of tuberculosis only, all types being admitted.

The Mother Superior, the Sisters, and the staff of St. Catherine's hosptial, East Chicago, issue through The Journal an invitation to visit the institution during the time of the September convention. St. Catherine's hospital, which is located in the Indiana Harbor section of East Chicago, is seven miles distant from the Hotel Gary, convention headquarters. The new hospital, which was opened in the spring, is one of the finest and largest in the state. It was built at a cost of $1,250,000, the money being furnished by the members of the Manufacturers' Association of the city of East Chicago, and the hospital Sisters, the Poor Handmaids of Jesus Christ. A number of the rooms in the institution were furnished by individuals, churches, lodges, and societies in East Chicago. The institution has a capacity of three hundred and twenty-five beds, and is a five-story



Gary Public Library.

most hospitals completely equipped for industrial surgery. Among its unique features is the color scheme employed. All rooms and wards have a home-like appearance, with such furnishings as colored drapes and floor lamps. The furniture throughout the building is of steel. In addition to the series of operating rooms, two obstetrical de-

partments, and completely-equipped laboratories, the hospital also has a training school for nurses.

Entertainment

The annual golf tournament will be held at the Gary Country Club, Wednesday morning, September 26, from 9:00 to 12:00. Wednesday afternoon from 1:00 to 5:30 there will be a tour of the steel mills. Wednesday evening at 8:00 o'clock will be the smoker and entertainment in the ballroom (mezzanine floor) of the Hotel Gary, when golf trophies will be presented. Thursday evening, September 27, at 7:00 p. m., there will be a banquet for physicians, wives and guests in the ballroom of the Hotel Gary.

Ladies' Entertainment

The ladies are promised royal entertainment with no dull moments. Wednesday evening, September 26, at 7:30, there will be a theater party at the Palace Theater. Thursday morning, at 8:00, the Woman's Auxiliary will have a breakfast meeting in the tea room of the Hotel Gary. At 9:30 o'clock Thursday morning a sight-seeing trip to Dunes State Park has been arranged and at 1:00 o'clock of the same day luncheon will be served at the Gary Municipal Pavilion. Following the luncheon a bridge party has been planned and at 7:00 p. m. of the same day there will be the banquet for all in the ballroom of the Hotel Gary. Friday morning at 9:15 o'clock there will be a special trip for the ladies through the steel mills.

On Wednesday the Woman's Auxiliary to the Indiana State Medical Association will meet in the afternoon from three to five at which time reports will be given by presidents of county auxiliaries. Mrs. Cregor, president of the Indiana Auxiliary, has invited Dr. George Daniels and Dr. C. E. Gillespie to greet the members of the Auxiliary at this meeting.

Daylight Savings Time

All of Lake County operates on daylight savings time, one hour faster than central standard time. The time given on the program throughout is based on this fact.



St. Mary's Mercy Hospital.

OFFICIAL CALL TO THE HOUSE OF DELEGATES

The next annual session of the Indiana State Medical Association will be held at Gary, September 26, 27 and 28, 1928.

The House of Delegates will be constituted as follows: Marion County, nine delegates; Allen County, two delegates; Lake County, four delegates; St. Joseph County, three delegates; Vanderburg County, two delegates; Vigo County, two delegates; the other seventy-eight counties, each one delegate; thirteen councilors; the ex-presidents, namely G. F. Beasley, C. S. Bond, M. F. Porter, W. N. Wishard, J. C. Sexton, G. W. McCaskey, J. B. Berteling, G. T. McCoy, T. C. Kennedy, W. F. Howat, Joseph R. Eastman, W. H. Stemm, C. H. McCully, David Ross, W. R. Davidson, C. H. Good, Samuel E. Earp, E. M. Shanklin, Charles N. Combs, and Frank W. Cregor. In addition to these, the president, secretary and treasurer, and the editor of THE JOURNAL, all without power to vote except in case

of a tie, when the president shall cast the deciding vote.

Blank credentials have been sent by the secretary to each county society, and the properly executed credentials for the delegates should be mailed immediately to Thomas A. Hendricks, 804 Hume-Mansur Building, Indianapolis, or brought to the session. No delegate will be seated unless wearing the official badge.

The House of Delegates will convene promptly at 6:30 p. m. on Wednesday, September 26, in the tea room (basement) of the Hotel Gary, and again at 7:00 a. m. Friday morning, September 28, in the tea room (basement) of the Hotel Gary.



Gary Public Schools Memorial Hall.

The order of business will be as follows:

1. Call to order by the president.
2. Roll call and seating of qualified delegates.
3. Reading of the minutes of previous meetings.
4. Report of the executive secretary.
5. Report of the treasurer.
6. Report of the chairman of the council.
7. Report of standing committees:
 a. Credentials.
 b. Administration and Medical Defense.
 c. Public Policy and Legislation.
 d. Bureau of Publicity.
 e. Medical Education and Hospitals.
 f. Scientific Work.
 g. Necrology.
 h. Industrial and Civic Relationship.
 i. Delegates to the A. M. A.
 j. Arrangements.
 k. Diphtheria.
 l. Budget.
 m. Postgraduate Study.
8. Reading of Communications.
9. Reading of Memorials and Resolutions.
10. Unfinished Business.
11. New Business.
12. Adjournment.

The election of officers will be the first order of business Friday morning at 7:00 o'clock. In addition to the regular officers, the terms of the following officers expire December 31, 1928, and their successors must be elected at the session: Delegates to the American Medical Association to succeed Harry Elliott, Brazil; David Ross, Indianapolis; and Alternates William H. Kennedy, Indianapolis, and F. S. Crockett, Lafayette, to be elected for the ensuing two years. Member of the Committee on Publicity to succeed Murray N. Hadley, Indianapolis, for the ensuing three years. Member of the Committee on Medical Education and Hospitals to succeed Walter McFadden, Shelbyville, for the ensuing three years. Delegates from counties comprising the third, sixth and ninth districts are reminded that the terms of their councilors will expire December 31, 1928, and new councilors should be elected to succeed the following:

Third district—Walter Leach, New Albany.

Sixth district—E. C. Denny, Milton.

Ninth district—F. S. Crockett, Lafayette.

Some of these elections may already have been held but they should be reported to the House of Delegates at this session for confirmation.

Thomas A. Hendricks,
Executive Secretary.

ANNOUNCEMENTS

All members and those accompanying them are requested to register upon their arrival. The Bureau of Information and Registration will be on the mezzanine floor of the Hotel Gary.

Members of the House of Delegates are reminded that the first meeting will be on Wednesday, September 26, at 6:30 p. m. in the tea room of the Hotel Gary. Members of the Council will have a luncheon meeting in the special dining room of the Hotel Gary (Room 317) at 11:00 a. m. Wednesday.

Essayists please bear in mind that all papers presented before the Association become the property of the Association, and therefore are not to be published or submitted for publication elsewhere than in THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION.

The election of officers will be the first order of business to come before the meeting of the House of Delegates Friday morning, September 28. No member of the House of Delegates is eligible to office, and delegates to the American Medical Association must have been members in good standing of the A. M. A. for the past two years.

You are requested to wear the official badge which is supplied when you register, and particularly so when attending or participating in the meetings. Members of the House of Delegates will have designating badges. Only accredited delegates are entitled to vote at any meeting of the House of Delegates or even to address the House of Delegates without special permission.

Register early. The booth for registration will be open throughout the session. Please have your pocket cards with you in order to avoid delay in registration. If you have paid your dues to your county society secretary *only recently* and have not yet received your membership card, present a receipt from your country secretary and you will be permitted to register. *Please get your badge and wear it.*

A demonstration of the health work carried on in the Gary public schools will be made especially for those physicians interested at the Horace Mann school, Wednesday morning, 8:15 to 10:15, September 26.

Attention of the members is called to the scientific exhibit which is to be held in connection with the general scientific sessions at the Gary meeting. In re-establishing the scientific exhibit as a feature of the annual meeting, the fact is recalled that the first scientific exhibit ever held at an American Medical Association was made by the late Frank B. Wynn, M.D., in June, 1897, at the Columbus, Ohio, meeting. This exhibit was reproduced and enlarged from an exhibit previously made at the state meeting of the Association.



Palace Theater and Gary Country Club

Make your hotel reservations at once. If you want to reserve accommodations at the Hotel Gary, you may use the blank printed below. Reservations may be made direct to the hotel or through the executive secretary's office.

Hotel Gary, Gary, Indiana:

Rate: Room with shower bath, one person.....$2.50
Room with tub bath, one person—$3.00, $3.50, $4.00, $5.00.
Room with bath, two persons—$4.50, $5.00, $6.00.
Room with twin beds, two persons—$6.00, $7.00.
Two rooms, connecting, with bath, for four persons, $10.00, $12.00.

Please reserve for me double room (with) (without) single twin beds connecting bath at $.....
per day from 1928 to 1928
Name
Address
Time of Arrival.....

The members of the class of 1907 will have an informal breakfast at 7:30 o'clock Wednesday morning,

the opening day of the convention. Wives and families of members are especially invited. Please make reservations for the breakfast through Ada E. Schweitzer, M.D., Room 120 State House Annex, Indianapolis, Ind.

Each member should bring his 1928 State Association membership card in order that there may be no delay in being registered. Only members who have paid their dues, and their guests, may register and attend meetings.

NOTES AND COMMENTS

E. M. SHANKLIN
CHAIRMAN, COMMITTEE ON ARRANGEMENTS
HAMMOND

Please remember that all of Lake County operates on daylight saving time, one hour faster than central standard time.

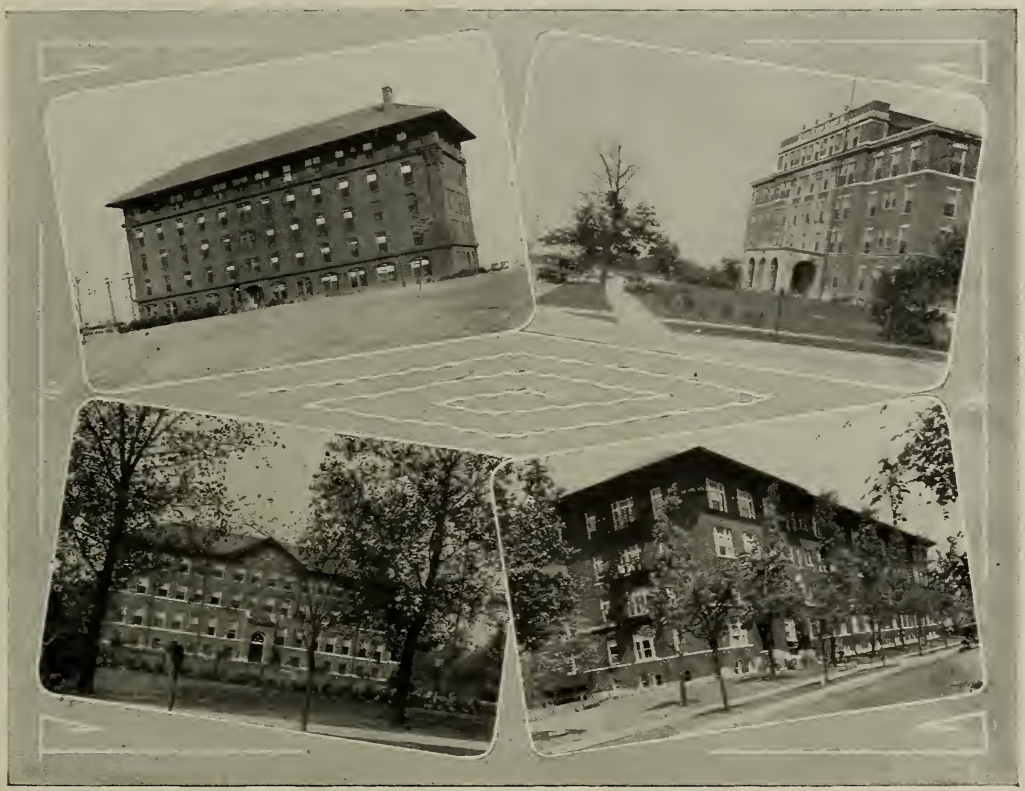
While this is known as the Gary Session, we wish to make it clear that Lake County is behind the program. This includes not only our membership of almost two hundred physicians, but every civic and commercial organization in this community of 250,000 souls.

The Wednesday afternoon trip through the Gary Works of the Illinois Steel Company is for men only; the ladies will make this trip on Friday morning. The hour for each party appears in the program announcement, elsewhere. Please be at the appointed place *on time,* as the trains leave on schedule.

We may appear over-enthusiastic about the smoker, Wednesday evening, but we do believe we will set a mark for others to shoot at for some years to come. The local members are determined to make this the biggest thing in the history of the Association. Many of your radio friends will be on the program. The "waiters" for the evening will be members of the Lake County Medical Society, thus assuring you of first-class service. The entertainment program starts at eight o'clock, that we may have ample time for the presentation of the full program.

While in Gary take a walk down South Broadway, into the cosmopolitan section, in the "good beer" days known as "The Patch." Here you will find a considerable population, speaking more than fifty tongues, practically every known race and nationality being represented. Many of these people adhere to their native country customs and a visit among them will be quite worth while.

Visiting members will find the rooms of the Gary Commercial Club, second floor of the Gary Hotel, open to them. Entrance from Sixth Avenue or from the mezzanine floor. The appointments of this club are unusually attractive and we are fortunate in having its officers extend to us club courtesies for the meeting.



Upper Left: Illinois Steel Co.
Lower Left: Nurses' Home.
Upper Right: Methodist Hospital.
Lower Right: Mercy Hospital.

Northern Lake County is liberally sprinkled with quaint and unusual "places to eat" from the road-side barbecue to pretentious restaurants. Fish dinners, long an institution hereabouts, provide an unusual repast for lovers of the finny tribe. For directions as to location of these places inquire at Information Bureau. Our girls know all the good spots in the county.

Information and registration headquarters will be on the mezzanine floor in charge of three competent attendants who are ardent boosters of the medical profession, know medical men, and have a happy knack of making you glad you came.

The Dune-Land trip for the ladies, Thursday morning, will be a revelation to many. It is one of the state's newer parks and many have no idea of the wonders therein. Nature lovers from all over the world have made special trips to see this unusual country, the

flora of which is said to be unequalled elsewhere. We regret that it is not possible to have arranged this trip for the men also.

Better get busy on hotel reservations. We believe we have plenty of rooms, yet an advance reservation means less trouble for you when you arrive. Reserve direct, or through the local committee, H. M. English, Chairman, 607 Broadway, Gary.

Information regarding garages will be given at the registration desk. All official garages are conveniently located near the hotel.

If you know your geography and the presidential history of your country you will have no trouble getting about Gary. East and west thoroughfares are avenues, numbered consecutively, beginning with Third Avenue, at the foot of Broadway. Broadway runs due north and south. Streets west of Broadway are named after presidents. Streets east of Broadway are named after states. There are practically no diagonal streets in Gary.

Bring the ladies with you; we have prepared to entertain them from the moment they arrive until they leave. You need not worry about them; they will have more fun than you, unless you are one of these chaps that can well withstand a hot pace.

"Old Doc Evans" has had one hectic time trying to get the "jack" to pay for all the parties we are putting on. About the time he catches up with the financial end of things some bird proposes something new and novel. These new and novel things do cost money, and Evans has been sorely put to it to meet the demand. However, the money is in the bank and everybody, locally, is happy. All we need is a crowd of good fellows to help us spend it.

The entertainment program opens on Wednesday morning, at 9:00 o'clock, with the annual golf tournament. This is to be held at the Gary Country Club. Prospective entrants are advised to send their names to T. B. Templin, M.D., 579 Broadway, Gary, who will arrange your transportation to the club. The usual list of prizes will be awarded the winners, this presentation being made during the smoker, the same evening. Due to the fact that we have an elaborate afternoon program, all golfers are urged to get in action early on Wednesday morning, that they may be back in Gary at noon and ready for the big party.

At 1:30 p. m. Wednesday, we start the trip through the Gary Works of the Illinois Steel Company. Entrance via the main gate, at the foot of Broadway, just north of the Gary Hotel. This trip is arranged through the courtesy of the General Superintendent, Mr. W. P. Gleason, who will see that every opportunity is afforded for inspection of the largest steel plant in the world in operation. Here you see the raw ore, the limestone and the coke leaving the lake carriers; you follow it through the furnaces; through the open hearth; into the soaking pit, and finally into the fabricating departments. The rail mill, the world's largest, is a sight alone worth a trip to Gary. The whole trip, a matter of many miles, is made aboard an observation train especially built for the purpose. Competent guides are in attendance, that the whole process of manufacture may be explained. This trip is for men only.



Upper Left: Moose Temple.
Upper Right: K. of C. Club Hotel
Lower Left: Elks' Temple.
Lower Right: Masonic Temple.

Wednesday night, at 8:00, comes the smoker, and here is where we expect to shine for we have a real party for you, and one that everyone can and will enjoy. Clean, wholesome entertainment will be provided by the best artists we were able to secure. The local doctors have been raising this jack-pot for the smoker for the past eight months; we have sweated over it; we have begged and borrowed; we have done almost everything but rob the poor box; but we *have* the money, and we have the entertainers. One of Benson's best orchestras will be with us for the evening, in addition to an all-star vaudeville of a dozen numbers. As to eats, we will set before you the best to be had in Indiana, and lots of it.

That there may be no embarrassment in asking for "second helpings," Dr. Ira Miltimore, chairman of the committee, has gotten together a band of twenty members, all of whom have been professional waiters in the better night clubs of the east, but who are now in the practice of medicine hereabouts. The smoker is to be held in the ball room, second floor, of the Hotel Gary.

Thursday noon is the time usually set for special luncheons and class reunions. The Service Men's luncheon is usually held at this time. Dr. Simon J. Young, 583 Broadway, Gary, has charge of the arrangements for the Service luncheon; Dr. R. N. Bills, 583 Broadway, Gary, is in charge of all class reunion luncheons. Those interested should communicate with their chairmen in advance of the meeting.

Our plans are complete; the table is set; the entertainers are rarin' to go; the sight-seeing special has steam up, bell a-ringin'; nothing remains but to have some one here to be entertained. We told you, at Indianapolis, last year, that we could and would take care of you royally; we are now ready to make good on that promise.

CONDENSED PROGRAM

(Schedule is made out on central daylight savings time)

Wednesday, September 26, 1928

Morning

9:00 a. m. to 6:00 p. m., Registration, mezzanine floor, Hotel Gary.
9:00 a. m. to 6:00 p. m., Technical Exhibit, mezzanine floor, Hotel Gary.
9:00 a. m. to 6:00 p. m., Scientific Exhibit, mezzanine floor, Hotel Gary.
9:00 a. m. to 12 m., Annual Golf Tournament. Eighteen low gross and medal play, Gary Country Club.
11:00 a. m., Meeting of Council. Luncheon at Hotel Gary, Room 317.

Afternoon

1:00 p. m. to 5:30 p. m., Trip through mills of Illinois Steel Company in observation trains. Men only.

Evening

6:30 p. m., Meeting of the House of Delegates, Tea Room, basement of Hotel Gary.
6:30 p. m., Dinner meeting, women physicians, Hotel Gary.
8:00 p. m., Annual smoker and entertainment, ballroom, mezzanine floor, Hotel Gary. Distribution of golf prizes.

Thursday, September 27, 1928

Morning

7:30 a. m., Breakfast meeting of county society secretaries, state officers and councilors, Hotel Gary. (Dutch treat.) Room 328, Hotel Gary.
8:00 a. m. to 5:00 p. m., Registration, mezzanine floor, Hotel Gary.
9:00 a. m. to 6:00 p. m., Technical Exhibit, mezzanine floor, Hotel Gary.
9:00 a. m. to 6:00 p. m., Scientific Exhibit, mezzanine floor, Hotel Gary.
8:30 a. m. to 1:00 p. m., General Scientific Meeting, ballroom, mezzanine floor, Hotel Gary.

Noon

Various fraternity, military and class luncheons and get-togethers in private dining rooms, Hotel Gary.

Afternoon

2:00 p. m. to 5:00 p. m., General Scientific Meeting, ballroom, mezzanine floor, Hotel Gary.
5:15 p. m., Meeting of sections to elect officers for 1929, ballroom, mezzanine floor, Hotel Gary.

Evening

7:00 p. m., Annual Banquet, ballroom, Hotel Gary. Presentation of certificates of merit to past presidents.

Friday September 28, 1928

Morning

7:00 a. m., Breakfast meeting, House of Delegates, Tea room, basement, Hotel Gary.
Meeting of the Council immediately following adjournment of the House of Delegates, Tea Room, basement, Hotel Gary.
8:00 a. m. to 12 noon, Registration, mezzanine floor, Hotel Gary.
8:30 a. m. to 12 noon, Technical Exhibit, mezzanine floor, Hotel Gary.
8:30 a. m. to 12 noon, Scientific Exhibit, mezzanine floor, Hotel Gary.
9:30 to 12 noon, General Scientific Meeting. ballroom, mezzanine floor, Hotel Gary.

PROGRAM FOR WOMEN'S ENTERTAINMENT AND WOMEN'S AUXILIARY OF THE INDIANA STATE MEDICAL ASSOCIATION

Wednesday, September 26

10:00—Informal Reception, Hotel Gary.
3:00 - 5:00 p. m.—Women's Auxiliary meeting, Hotel Gary.
7:30 p. m.—Theater party, Palace Theater.

Thursday Morning, September 27

9:30 a. m.—Sightseeing trip to Dunes State Park.

Thursday Afternoon

1:00 p. m.—Luncheon, Gary Municipal Pavilion, Miller, Indiana.
2:30 p. m.—Bridge at Gary Municipal Pavilion.

Thursday Evening

7:00 p. m.—Banquet, Hotel Gary.

Friday, September 28

Morning

9:15 a. m.—Special trip for ladies through the steel mills, starting from the Hotel Gary, at 9:15 a. m.

OFFICIAL PROGRAM OF THE ANNUAL SESSION OF THE INDIANA STATE MEDICAL ASSOCIATION

To Be Held At Gary, Lake County, Indiana, September 26, 27, 28, 1928

House of Delegates

First meeting in Tea Room, basement, Hotel Gary, Wednesday, September 26, at 6:30 p. m.
Second meeting, Hotel Gary, Friday, September 28, at 7:00 a. m. (Breakfast meeting, Tea Room, basement, Hotel Gary.)

Council

First meeting, luncheon, special dining room, Room 317, Hotel Gary, Wednesday, September 26, at 11:00 a. m.
Second meeting, Friday, September 28, immediately upon adjournment of House of Delegates, Tea Room, basement, Hotel Gary.
Additional meetings at the call of the chairman of the council.

General Meetings

All scientific meetings will be held in the ballroom on the mezzanine floor of the Hotel Gary, Thursday morning and afternoon, September 27, and Friday morning, September 28.

Secretaries' Meetings

County Society secretaries' breakfast and conference at 7:30 a. m., Thursday, September 27, Room 328, Hotel Gary.

Meeting of Women Physicians

Dinner meeting, Hotel Gary, 6:30 p. m., Wednesday, September 26.

Scientific Exhibits

Wednesday, Thursday and Friday, mezzanine floor, Hotel Gary.

Technical Exhibits

Wednesday, Thursday and Friday, mezzanine floor, Hotel Gary.

Registration

Wednesday, 9:00 a. m., until Friday 12 noon, mezzanine floor, Hotel Gary.

Entertainment

Golf tournament, Gary Country Club, Wednesday morning, September 26, 9:00 to 12:00.

Tour of steel mills Wednesday afternoon, September 26, 1:00 to 5:30.

Smoker and entertainment, ballroom, mezzanine floor, Hotel Gary, Wednesday evening, September 26, 8:00 p. m.

Reception for ladies, Hotel Gary, Wednesday afternoon, September 26, 2:00 to 3:00.

Business meeting of Women's Auxiliary, Hotel Gary, Wednesday afternoon, September 26, 3:00 to 5::00.

Theater party for ladies, Palace Theater, Wednesday evening, September 26, 8:15 p. m.

Trip to dunes of Lake Michigan for women Thursday morning, 9:30 o'clock.

Lucheon, Thursday afternoon, September 27, at Gary Municipal Pavilion, for ladies, 1:00 o'clock.

Bridge, Thursday afternoon, September 27, at Gary Municipal Pavilion, 2:30 p. m.

Banquet for physicians, wives and guests, ballroom, mezzanine floor, Hotel Gary, Thursday evening, 7:00 p. m.

Trip through steel mills, for ladies, Friday morning, September 28, starting from Hotel Gary at 9:15 a. m.

SCIENTIFIC PROGRAM

GENERAL MEETING

Thursday, September 27, 1928, 8:30 a. m., Ballroom, Hotel Gary, Mezzanine Floor

Morning Session

8:30 a. m.—Meeting called to order by President George R. Daniels, M.D., Marion.

8:40 a. m.—Introduction of Mayor Williams of Gary, by E. M. Shanklin, M.D., General Chairman.

8:45 a. m.—Address of welcome—Mayor Floyd Williams of Gary.

9:00 a. m.—President's address—George R. Daniels, M.D.

9:30 a. m.—"A Laboratory Diagnosis of Tuberculosis," W. H. Ordway, M.D., Assistant Medical Director, Metropolitan Life Insurance Company, Mount McGregor, New York.

10:00 a. m.—Discussants: (1) J. A. Wynn, M.D., Indianapolis; (2) Eric A. Crull, M.D., Fort Wayne.

10:30 a. m.—W. D. Little, M.D., Indianapolis. Subject, "Thyroid."

11:00 a. m.—Discussants: (1) Miles Porter, Sr., M.D., Fort Wayne; (2) G. G. Eckhart, M.D., Marion.

11:30 a. m.—Henry Frederick Helmholz, Professor of Pediatrics, University of Minnesota Medical School. Subject, "Pediatrics."

12:00 m.—Discussants: (1) Milo K. Miller, M.D., South Bend; (2) Reuben A. Craig, M.D., Kokomo.

Afternoon Session

2:00 p. m.—Palmer Findley, M.D., President of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Omaha, Nebraska. Subject, "Pelvic Peritonitis."

2:30 p. m.—Discussants: (1) A. M. Mendenhall, M.D., Indianapolis; (2) E. E. Padgett, M.D., Indianapolis.

3:00 - 3:30 p. m.—Otis B. Nesbit, M.D., and Margaret G. Smythe, M.D., Gary. Subject, "Health Work in the Gary Public Schools."

3:30 - 4:00 p. m.—Edward Francis, M.D., United States Public Health Service. Awarded 1928 Gold Medal for research by A. M. A. Subject, "Tularaemia and Undulant Fever."

4:00 - 4:30 p. m.—Albert Keidel, M.D., Associate Professor of Clinical Medicine, Johns Hopkins University School of Medicine, Baltimore. Subject, "The Treatment of Syphilis."

4:30 p. m.—Discussants: (1) Herman M. Baker, M.D., Evansville; (2) O. L. Fisher, M.D., Richmond.

5:00 p. m.—Meeting of sections and elections of section officers to follow immediately upon close of scientific meeting.

Annual Banquet

Thursday evening, September 27, Ballroom Hotel Gary.

Introduction by Thomas W. Oberlin, M.D., Hammond, toastmaster.

Presentation of certificates of merit to past presidents.

Address: "The Worldly Rewards of Medicine," by William Allen Pusey, Chicago, past president of the American Medical Association.

Friday, September 28, 1928

Morning Session

9:30 to 11:30 a. m.—Symposium, "Diabetes." This subject is to be discussed from the standpoint of interest to the general practitioner and not from the standpoint of the specialist.

Joseph C. Beck, M.D., Associate Professor, University of Illinois College of Medicine. "Diabetes" from the standpoint of oto-laryngology with special reference to men in general practice.

Harry Searles Gradle, M.D., Chicago. "Diabetes" from the standpoint of the ophthalmologist with special reference to men in general practice.

Sidney Strauss, M.D., Associate Professor of Medicine, University of Illinois College of Medicine. "Diabetes" from the standpoint of the internist.

11:30 a. m.—Discussants: (1) Roscoe Hamilton Beeson, M.D., Muncie; (2) Marcus Ravdin, Sr., M.D., Evansville; (3) C. P. Clark, M.D., Indianapolis.

SCIENTIFIC EXHIBIT

(Mezzanine floor, Commercial Club Room, Hotel Gary.)

"Visual Teaching in Neurology and Neuro-Diagnosis," Albert E. Sterne, M.D.

Indiana University School of Medicine:

(1) "Distribution of Diseases in Indiana," Thurman B. Rice, M.D.

(2) Display of Pathological Specimens by the Department of Pathology.

(3) Exhibit of Pathological Specimens and Microscopic Diagnosis of Tissue. H. M. Trusler, M.D.

(4) The Technique and End Results of Cleft Palate and Hare-lip Repair. Chas. L. Cabalzer, M.D.

(5) Exhibit of Clinical Work at the James Whitcomb Riley Hospital, Department of Orthopedic Surgery, L. L. Shuler, M.D.

COMMITTEE ON ARRANGEMENTS

The Arrangements Committee for the coming convention follows:

E. M. Shanklin, chairman, general arrangements committee.

E. E. Evans, chairman, finance committee.

H. M. English, chairman, hotel and restaurant committee.

Ira Miltimore, chairman, entertainment committee.

H. C. Parker, chairman, automobiles and garages committee.

S. H. Crossland, chairman, publicity committee.

T. B. Templin, chairman, golf committee.

O. B. Nesbit, chairman, lantern committee.

A. J. Lauer, chairman, ladies entertainment committee (to assist the ladies committee).

C. C. Brink, chairman, reception committee.

O. C. Wicks, chairman, registration committee.

O. B. Nesbit, chairman, public health meeting.

R. N. Bills, chairman, fraternity and class reunions committee.

S. J. Young, chairman, military service committee.

F. M. Doty, chairman, women physicains' meeting.

Mrs. O. C. Wicks, chairman, ladies committee.

REPORT OF COMMITTEE ON CREDENTIALS

House of Delegates, Indiana State Medical Association:

Gentlemen:—Your committee has in the year past done a great deal of work in trying to inaugurate a different system as to registration of members in the House of Delegates, and at this time has not been able to make any change for this year, and we recommend that every County Medical Society have their delegate come to our Gary meeting with the proper credentials, as it will save themselves as well as the committee a great amount of time and annoyance.

Committee,

GEORGE D. MILLER, M.D., Logansport, Chairman.
HARRY M. PELL, M.D., Brazil.
CHARLES STOLTZ, M.D., South Bend.

REPORT OF EXECUTIVE SECRETARY

House of Delegates, Indiana State Medical Association:

Gentlemen:—

The annual reports of your various committees show better than anything your secretary may write the progress that is being made by the Indiana State Medical Association.

These reports deserve the attention of every member of the Association as from them may be gained some conception of the effective and unselfish service of your councilors, committeemen and officers toward the advancement of scientific medicine.

As detailed as these reports are, they give only a mere idea of the hours of faithful service by your committeemen in an attempt to solve the constantly arising problems that face the medical profession today—problems which cannot be solved in many instances by any one single committee in any one year and which may never be solved to the complete satisfaction of every member of the Association but which nevertheless must be attacked with vigor, hope and broad intelligence.

As difficult as the solution of these problems may be, we believe progress is being made and benefits are being received by the profession and the public alike from the tireless efforts of your committees. But the whole credit cannot be given to your officers, committeemen and council, for the final measure of success and accomplishment lies with the individual members of the Association who have been unusually active, interested, responsive and helpful during the year just passed. In fact, the activities of the Indiana State Medical Association are only possible thorugh the harmonious, co-operative, interested and active service of each individual physician.

Therefore, at this time, just before the annual session when the yearly "check-up" is made it may be said with confidence that 1928 has been an unusually successful year for the Association. We have more members, we have fewer "dead" county societies, we have more "live" secretaries and county society officers, and perhaps it may be said that never before have so many problems been met with such vigorous action and such a degree of whole-hearted co-operation in the history of the Indiana State Medical Association.

The membership in the State Association for 1928 totals 2697, a gain of forty-seven members over last year.

No report from the headquarters office would be complete without a mention of the resignation during the year of Mrs. Louise Gillespie from the office staff. Mrs. Gillespie had been connected with the work of the medical profession in Indiana for many years, serving fourteen years as secretary to the late John N. Hurty, M.D., secretary of the State Board of Health. With the establishment of the office of the Bureau of Publicity in Indianapolis in January, 1924, Mrs. Gillespie became connected with the Indiana State Medical Association. Her intimate touch with the office work, her knowledge of the medical association personnel, and her efficient help is much missed.

Respectfully submitted,

THOMAS A. HENDRICKS,
Executive Secretary.

REPORT OF TREASURER

House of Delegates, Indiana State Medical Association:

Gentlemen:—Our report this year consists of a statement from the certified public accountant and a comparative statement of the application of funds for the period from January 1 to August 1 for the years of 1927 and 1928 which is self-explanatory.

August 29, 1928.

Wm. A. Doeppers, M. D.:

The attached statement shows the application of funds for the period of January 1, 1928, to July 31, 1928, as reflected by the books at that date.

R. E. WELCH.

Comparative statement of application of funds for the period from January 1st to August 1st for the years of 1927 and 1928:

INCOME

	1927	1928	
Membership Dues	$18,424.00	$18,767.00	$ 343.00
Interest on Liberty Bonds	106.25	106.25	
Interest on Certificate of Deposit and Checking Account	1,012.50	1,273.76	261.26
Unexpended Balance of Contingent Fund		300.00	300.00
Check to reimburse Legislative Fund	25.28		(25.28)
Total Receipts	$19,568.03	$20,447.01	$ 878.98

EXPENDITURES

Executive Secretary's Office	$ 5,365.24	$ 6,271.37	$ 906.13
Publicity Committee	245.60	308.18	62.58
Public Policy	2,507.78	120.59	(2,387.19)
Journal	5,248.00	5,338.00	90.00
Council	197.41	227.20	29.79
Treasurer	186.50	217.50	31.00
Annual Session	141.95	7.62	(134.38)
Miscellaneous Committee	69.32	152.50	83.18
Attorneys Fees	300.00	175.00	(125.00)
Medical Defense Fund	475.00	1,650.00	1,175.00
Contingent Fund	2,500.00		(2,500.00)
Better Business Bureau		200.00	200.00
Total Expenditures	$17,236.80	$14,667.96	($2,568.84)
Net Income to August 1st	$ 2,331.23	$ 5,779.05	$3,447.82
Checking Accounts Balance at January 1st	2,220.06	4,315.26	2,095.20
Less amount transferred to Certificate of Deposit		(5,000.00)	(5,000.00)
Checking Accounts Balance at August 1st	$ 4,551.29	$ 5,094.31	$ 543.02
Statement of Surplus at August 1st:			
Surplus at January 1st	$25,243.35	$27,015.26	$1,771.91
Adjustment of Contingent Fund		(2,500.00)	(2,500.00)
Surplus after Adjustment	$25,243.35	$24,515.26	($ 728.09)

Net Income to August 1st	2,331.23	5,779.05	3,447.82
Surplus at August 1st	$27,574.58	$30,294.31	$2,719.73

ANALYSIS OF SURPLUS ACCOUNT

Certificate of Deposit with Meyer Kiser Bank	$15,000.00	$20,000.00	$5,000.00
Liberty Bonds	5,000.00	5,000.00	
Deposits in Bankers Trust Co.	3,023.29	200.00	(2,823.29)
Meyer Kiser Checking Accounts	4,551.29	5,094.31	543.02
Total Surplus	$27,574.58	$30,294.31	$2,719.73

Members paid up at July 31, 1927	2632
Members paid up at July 31, 1928	2681
Increase	49

Parenthesis () denotes decrease.

Respectfully submitted,

WILLIAM A. DOEPPERS, Treasurer.

REPORT OF THE CHAIRMAN OF THE COUNCIL

House of Delegates, Indiana State Medical Association:

Gentlemen:—The principal acts of the Council during the past year follow:

FIRST MEETING, INDIANAPOLIS, INDIANA, SEPTEMBER 28, 1927.

Roll call showed eleven of the thirteen councilors present along with the president, the president-elect, and treasurer of the Association, and the editor of THE JOURNAL. F. C. Warnshuis, M.D., speaker of the House of Delegates of the American Medical Association and secretary-editor of the Michigan State Medical Association, was present as the guest of honor. Short reports made by each councilor showed an active and prosperous condition of the State Assocaition as a whole.

The question of the disposition of White County was brought up. White County has been a part of the Tenth District, and due to a lack of natural connections with that district it was thought best to place it in some other district.

Preliminary report upon the technical exhibit which was held in connection with the meeting showed that there were thirty-nine exhibitors occupying forty-eight booths.

The Council recommended that the Association take a membership in the Better Business Bureau.

Resolution complimenting the press of Indiana upon the Briggs Diploma Mill expose adopted by the Council.

The Council authorized officers of the State Medical Association to make a formal presentation of a charter to the members of the Harrison County Society at a meeting of the House of Delegates.

SECOND MEETING, INDIANAPOLIS, INDIANA, SEPTEMBER 30, 1927

Ten councilors of the thirteen districts were present along with the retiring president, present president, and president-elect of the State Association, treasurer of State Association and editor of THE JOURNAL.

Discussion concerning the licensing of drugless healers under new amendment to medical practice act.

MID-WINTER MEETING OF THE COUNCIL, INDIANAPOLIS, DECEMBER 16, 1927

All members of the Council were present except those of the eleventh and twelfth district. The president, president-elect, retiring president, and treasurer of the Association, and editor of THE JOURNAL were also present. The meeting was called to order at 10:15 and was not adjourned until late in the afternoon, more business coming before the Council than ever before in its history. Report of the councilors by districts showed every district in good condition despite the fact that a few counties were not actively organized. Reports of the district showed the unusual value of post-graduate work and the general report is that post-graduate courses are a good thing in all districts. The value of joint meetings between doctors, dentists and lawyers was discussed.

Preliminary report for Gary convention made to Council.

Resolution passed against proposed activities of the New England Anti-vivisection Society to introduce into Congress a bill for the exemption of dogs from vivisection.

Reports from the chairmen of the various standing committees received.

The following counties were listed as dead from a medical organization standpoint:

Marshall. As most of the physicians in this county belong and attend meetings in adjoining county societies it has been thought best not to have a Marshall County Medical Society.

Starke.

Crawford.

Brown.

Special committee reports that White county should be taken from the tenth district and added to the ninth district, upon the request of the officers of the White County Medical Society.

The Council went on record recommending and suggesting that each county society give one meeting a year to medical economics.

Dr. A. L. Marshall and Dr. David Ross, Indianapolis, were unanimously re-elected as members of the Executive committee.

Dr. William R. Davidson was re-elected chairman of the Council.

Respectfully submitted,

WILLIAM R. DAVIDSON,
Chairman of the Council.

REPORTS FROM COUNCILOR DISTRICTS

First Councilor District

No meeting of the district organization has been held during the past year, owing to the multiplicity of medical meetings. Each of the hospitals instituted monthly clinical meetings conducted by the staff of each in turn.

The one feature of the year in the district was the re-organization of the Warrick County Society. Formerly this was very active and several years ago it became dormant from removals, deaths, and inactivity. There was the general desire for a re-organization and the spirit shown was very creditable. Like most of the societies in the outlying part of the district, there has been a gradual decline in number of physicians in the rural districts. However, this should not prevent a society however small from being a positive factor in the community. There was no little interest shown in the post-graduate work and lecture extension course. Otherwise there is nothing further to report.

W. R. DAVIDSON, Councilor.

Second Councilor District

The members of the medical profession, as well as the medical societies in each county of the Second District, are apparently in good condition. The society of each county meets practically each month except about three months during the summer. Practically all the profession in each county are members of their respective societies, and the meetings are usually well attended. Practically all of the counties occasionally have outside men to address their societies.

During the first half of the year Monroe county gave clinics at the City hospital, having physicians from Indianapolis to conduct these clinics. Several of the Societies meet with the dentists of their respective counties at least once a year, and some of the societies have associate members of the dentists.

The medical profession throughout the district is rapidly decreasing. For instance, in Owen county there are six members of the society, and all belong that are eligible.

The district has not met as a society for several years, and while it is impossible to have a meeting this year it is hoped that during the following year at least one meeting will be held. Owing to the shortage of physicians it would seem a good plan for at least two or

three counties to meet together at least once or twice a month.

G. D. Scott, Councilor.

Third Councilor District

Conditions throughout the district are about as usual, and probably as good as could be expected. The district meetings are held in the spring and fall with good attendance and splendid programs, which I think are exceedingly beneficial and interesting, owing to the fact that in this district there are a few counties which seem to be unable to hold regular county meetings, or at least are unable to have regular scientific programs. This defect is largely a matter of indifference, and will gradually improve as professional fraternity grows and mutual interest develops in the mind of medical men. I hope to visit some of the more distant counties this fall.

W. J. Leach, Councilor.

Fourth Councilor District

The Fourth District Medical Society is in very good working order and although there has not been a large increase in membership within the last year it is safe to say that practically every ethical physician in active practice is a member of his county medical society.

The District meeting which was held at Dillsboro in the spring was well attended.

One of the features of the Fourth District is the Tri-County Medical Society, composed of Jackson, Jennings and Bartholomew counties, which meets regularly throughout the year except the summer months.

H. P. Graessle, Councilor.

Fifth Councilor District

The Parke-Vermilion Society is still in the unhealthy condition that it has been for several years. Both Parke and Vermilion counties have been quite a problem. A few years ago they were joined in the hopes of bettering the condition. For a while there was some improvement. For the past year or two it has been quite difficult to get satisfactory meetings.

This summer I made the suggestion that the counties again each have their own organization for the purpose of election of officers and representation by delegates to the state society, the scientific programs all to be held with Vigo county. Paved roads and interurban service make this very easy and desirable. Many of the physicians in both counties have expressed their approval of this plan, but before it is carried out, I place it before the Council meeting for advice and suggestion.

Clay and Putnam counties are both coming along very satisfactorily.

Vigo county is in good condition, and this past year held many interesting meetings with clinics at the hospitals, addresses from outside men, and one very interesting meeting on economics. These meetings are also freely attended by doctors from all over the district to whom notices are always sent.

Joseph H. Weinstein, Councilor.

Sixth Councilor District

1. The matter of the advertisement of the Koch Cancer Cure in connection with the Y. M. C. A. health exhibit at Richmond last year (1927) was carefully gone into, and it was found that the State Board of Health, the Publicity Bureau of the State Medical Association and the Richmond Y. M. C. A. were in no wise responsible for the distribution of such advertisements. The Richmond Y. M. C. A. is to be highly commended for its attitude in the matter of public health meetings.

2. The district meeting was held at Rushville in May. Matters relating to the enforcement of the medical practice act and to the interest every physician should take in measures proposed for laws, to come before the 1929 session of the legislature, were stressed by the councilor. The meeting was fairly well attended.

3. Two county societies were visited; also a meeting of the Henry, Rush, Hancock and Shelby county societies was attended.

4. All county medical societies in the sixth district are meeting and are in good condition, due, I think, to the fact that much outside talent appears before the societies in this district. As yet no local postgraduate work has been undertaken.

Edgar C. Denny, Councilor.

Seventh Councilor District

Marion, Hendricks, Morgan and Johnson counties comprise the seventh district.

Marion county meets weekly, on Tuesday night, at Indianapolis, from October 1, to June 1. Average attendance about one hundred twenty-five. Paid members, four hundred fifty-seven. Dropped for non-payment, eight. Visitors on program during year, twelve. Local men taking part on programs during year, seventy-one.

Hendricks county meets at Danville, Indiana, once a month, except summer months. All practicing physicians in county are members. Attendance is good and the meetings are made interesting. Occasionally visitors are called in for programs. The district meeting was held in this county last year with a good attendance and a good program. No irregulars in county.

Morgan county meets at Martinsville, Indiana, twice a month, except summer months. Membership about thirty. During 1926-1927 year, attendance was poor, due to personal feelings; 1927-1928 has been better. No irregular practitioners in county. Society dues are well paid up.

Johnson county meets yearly in the fall and elects officers for the year. As a rule local meetings are not held thereafter. This is due to feeling existing between certain members. The situation has been somewhat improved, but is far from good yet. Many of the members attend meetings in other counties. One or two irregulars are reported in this county.

E. E. Padgett, Councilor.

Eighth Councilor District

The Delaware-Blackford and Madison County units of the State Association, in the English District, are to be congratulated upon the work they have been doing in the past year, as known by personal observation and attendance. Letters to secretaries of the Jay and Randolph County units concerning their work were not answered. Favorable reports, however, have been received from some of their members.

M. A. Austin, Councilor.

Ninth Councilor District

The Ninth Councilor District is in a good sound condition, with the exception of Boone county. Every other county is well organized as an efficient county organization with a full membership. Practically all eligible physicians are enrolled in these county societies. Especially strong organizations are to be found in the Fountain-Warren Society, the Montgomery County Society, the Clinton County Society and the Tippecanoe County Society, these being the counties with the largest possible membership.

Your Councilor was able to visit all but one of the counties of the district in company with the president of the district society.

The district meeting was held on the 17th of May at Lafayette, with an outstanding program consisting of dry and operative clinics during the morning hours at each of the two local hospitals; a luncheon meeting of the House of Delegates at the Lafayette Country Club; and a scientific program of dry clinics by out of district and local doctors. In the evening the annual district dinner was held at the Home Economic Department of Purdue University, where the after-dinner entertainment consisted of an illustrated travelogue by Professor Enders of the Biology Department, giving details of his trip to the wild life preserve on an island in one of the lakes of the Panama Canal Zone. At 8 o'clock the public meeting was held and the address was given by Dean

Emerson of the Indiana Medical College on "Mental Hygiene."

At the luncheon meeting of the House of Delegates the situation concerning the lack of organization in Boone county was taken up and a decision was reached to have the counties of the district surrounding Boone county, go in at some date and put on a meeting for the local doctors. This was done on June 26th. Some sixty-five doctors were present at the Uhlen Country Club, including Dr. Daniels, our state president, the members of the executive committee of the state society, and our executive secretary. The immediate result was a great outstanding success but the the effect upon the Boone county doctors from the standpoint of resuscitating their county organization still remains a matter of doubt as well as guarded prognosis.

Respectfully submitted,
FRANKLIN SMITH CROCKETT, Councilor.

Tenth Councilor District

The affairs of the Tenth District are in a very satisfactory condition from a society standpoint. In membership and attendance, the Jasper-Newton Society has been an outstanding leader for years, and during the last year has lived up to its reputation. The Tenth District Society was entertained at the home of George Ade, Hazelden, in June, and Mr. Ade not only placed his golf course, flower beds and other luxuries at the disposal of the doctors, but cheered and entertained by his presence. A most enjoyable time was had by a good-sized attendance, and two particularly instructive papers were read at the afternoon meeting.

Porter county's membership remains the same as last year, and all members are reported to the Councilor as so well-behaved that no complaint has reached his ears.

Lake County, principally because of having one of the best secretaries in the world, has been going good. Few complaints have reached the Councilor, and none has been of a serious nature. Thirty-two new members have joined the Society this year, and with the exception of three old members who have not paid their dues, there are only four eligible men in the country who are not members. This record is the result of the personal solicitation of the secretary, Dr. Shanklin. The society has had an unusually interesting series of meetings this year, and expects the meetings of the State Association to be a fitting climax to the year's endeavors.

EDWARD E. EVANS, Councilor.

Eleventh Councilor District

As councilor of the eleventh district of the Indiana State Medical Association I wish to report conditions in the eleventh district are in fine shape. Each county society is very active, and has at least nine monthly meetings each year.

At least ninety-eight per cent are members of our district society which meets twice yearly. Our motto, "None better in the state" has outlived its usefulness and is now, "The best in the state."

IRA E. PERRY, Councilor.

Twelfth Councilor District

The condition of the organized medical profession in the Twelfth District is, on the whole, quite satisfactory. The following is a report on the various county societies:

1. Adams county. The society meets twice a month and every eligible physician in the county is a member.

2. Allen county. The society meets every week except during the months of July and August. Once a month there is a dinner meeting with a speaker from out of the city. There are probably three desirable medical men in the city who do not belong to the society.

3. DeKalb county. The County Medical Society holds but one regular meeting a year. However, it is affiliated with three other societies in the Northeastern Academy of Medicine. There are several desirable medical men who do not belong to the Society but there seems to be no method by which they can be induced to join.

4. LaGrange county. County society meets alone once a year but is also affiliated with the Northeastern Academy of Medicine. Every physician in the county is a member of the society in good standing.

5. Steuben county. The society has monthly meetings but the attendance at these meetings is rather poor. It is also affiliated with the Northeastern Academy of Medicine. There are fifteen medical men in the county eligible for the society membership but only eleven of these belong. An unsuccessful effort has been made to induce the other four men to join the organization.

6. Noble county. County Society has had two meetings this year. It is also affiliated with the Northeastern Academy of Medicine. Every physician in the county is a member, in good standing, of the county and state societies.

7. Wells county. County society holds monthly meetings. Every desirable medical man in the county belongs to the society.

8. Whitley county. County Society meets on the second Tuesday of each month. There are possibly one or two desirable medical men who do not belong to the organization.

H. O. BRUGGEMAN, Councilor.

Thirteenth Councilor District

This district society and the various component county societies are all in excellent working condition, holding regular meetings which are well attended by the membership and by invited guests from adjacent territory.

The programs presented at the stated meetings are of a high order of educational excellence and represent a constructive effort to keep the profession informed of the advances in medicine and surgery.

The district and special county meetings are presenting clinics and discussions dealing with live medical and surgical topics under the guidance of leaders brought in from various large medical centers.

Individually and collectively the counties of this district can truthfully be reported as being in excellent condition.

H. M. HALL, Councilor

REPORT OF THE EXECUTIVE COMMITTEE

House of Delegates, Indiana State Medical Association:
Gentlemen:—

I INTRODUCTION.

According to the Constitution and By-Laws the executive committee is required to make a report at this time to the House of Delegates and to the Council. The following report is made to both bodies.

1. With the adoption of the new Constitution, which defined in definite terms the duties and powers of the executive committee, the scope of work done by this committee has been increased.

2. Regular monthly meetings were held by the committee but many of these meetings were attended only by the Indianapolis members of the committee. For this reason the committee reiterates its recommendation that in order that the executive committee may be assured of a quorum at its regular monthly meetings three members of this committee should reside in or within a short distance from Indianapolis.

3. Your committee also reiterates its recommendations of last year, that the By-Laws creating your committee should be amended to state definitely the term of office of each committeeman who is appointed by the Council.

II GENERAL ACTIVITIES.

1. *Membership in the Better Business Bureau.* Following the recommendation of the Council the Executive Committee joined the Better Business Bureau and several cases were referred to the Bureau during the year. One of the most notable actions resulting from these cases referred to the Bureau was that in which an advertising cancer quack charged a large sum of money, a part of which the Better Business Bureau forced this charlatan

to refund. Through the Better Business Bureau "Doctor" Rodney Madison, who is a drugless healer, was unable to advertise his Vitrona apparatus in the Indianapolis newspapers and as a result it is reported his company went into bankruptcy. The Vitrona apparatus consisted of a belt which was supposed to radiate a sort of electrical energy through the system.

2. *Survey of dispensing and prescribing physicians.* With the co-operation and under the direction of the executive committee of the Indiana State Medical Association, the Pitman-Moore Company, of Indianapolis, conducted a survey classifying the prescribing and dispensing physicians of the state. Questionnaires were sent to each physician in Indiana and a summary of the results follows:

"Taking the physicians' directory of the A. M. A. as a basis, and assuming that the percentage of physicians listed in Indiana, who are in active practice, is the same as the percentage for the whole country, there are approximately 3,700 physicians in active practice in Indiana.

"Returns have been received from 2,471 physicians, and this number is divided as follows:

Dispensers	1606
Part Dispensers	598
Prescribers	267

"In making the above divisions, physicians who stated that they dispensed to ten percent or less of their patients were counted as prescribers, and those dispensing to twenty-five to seventy-five percent of their patients were counted as 'part dispensers' while those reporting as dispensing to seventy-five percent or more were counted as dispensers.

"If it is logical to assume that the approximately thirty-three and one-third percent who have not yet reported will about correspond with the two-thirds already heard from, the complete figures for the state would be approximately as follows:

Dispensers	2409
Part Dispensers	400
Prescribers	897

"The returns from the larger cities in the state may also be of interest. They are as follows:

	Disp.	Part disp.	Presc.
Fort Wayne	30	19	35
Frankfort	11	1	
Muncie	26	2	10
Elkhart	21	1	1
Goshen	14		
Kokomo	23	4	4
Gary	18	23	23
Hammond	16	18	8
Indianapolis	97	60	209
South Bend	29	23	16
Mishawaka	12		
Evansville	20	14	54
Terre Haute	16	13	34
Richmond	21	4	7

"In the questionnaire sent to individual physicians in the more heavily populated counties, the question was asked whether dispensing was increasing or decreasing. Five hundred ninety-two physicians replied that dispensing was increasing in their locality and three hundred seven think it is decreasing. These figures, however, are not of especial value in obtaining a correct picture of the situation since in the majority of instances it was noted that physicians who are doing more or less dispensing believe dispensing to be on the increase, while those who write prescriptions entirely believe it to be decreasing. In other words, most of the opinions on this point were tinctured by the individual physician's own practice."

3. *Certificates of merit for past presidents.* Feeling that the high place held by the Indiana State Medical Association is the direct outcome of wise and unselfish leadership by its presidents down through the years, the executive committee of the Association has authorized the preparation of certificates of merit for each past president. The presentation of these certificates to the past presidents will be the outstanding ceremony of the seventy-ninth annual meeting of the Association, which is to be held at Gary, Indiana, September 26, 27 and 28. These certificates of merit will be awarded at the annual banquet, Thursday evening, September 27, at the Hotel Gary. The executive committee, convention arrangements committee, and officers of the Association are making plans to have this the feature event not only of the annual banquet on Thursday evening but of the annual meeting, and hope that every living ex-president will be present.

The living ex-presidents of the Indiana State Medical Association follow:

	Elected	Served	Born
George F. Beasley, Lafayette	1892	1893	1841
Chas. S. Bond, Richmond	1894	1895	1856
Miles F. Porter, Fort Wayne	1895	1896	1856
Wm. N. Wishard, Indianapolis	1897	1898	1851
John C. Sexton, Rushville	1898	1899	1859
Geo. W. McCaskey, Fort Wayne	1900	1901	1853
John B. Berteling, South Bend	1902	1903	1860
George T. MacCoy, Columbus	1904	1905	1846
Thos. C. Kennedy, Indianapolis	1909	1910	1862
William F. Howat, Hammond	1911	1912	1869
Joseph R. Eastman, Nashville	1917	1918	1871
Wm. H. Stemm, North Vernon	1918	1919	1861
Charles H. McCully, Logansport	1919	1920	1868
David Ross, Indianapolis	1920	1921	1865
William R. Davidson, Evansville	1921	1922	1875
Charles H. Good, Huntington	1922	1923	1860
Samuel E. Earp, Indianapolis	1923	1924	1858
E. M. Shanklin, Hammond	1924	1925	1875
Charles N. Combs, Terre Haute	1925	1926	1879
Frank W. Cregor, Indianapolis	1926	1927	1873

III MEDICAL DEFENSE ACTIVITIES.

Again your committee takes keen pleasure in reporting that the members of the Indiana State Medical Association receive their medical defense protection cheaper than physicians in any other State. Although Indiana continues to supply its medical defense with a cost of only seventy-five cents per member, in some other states the sum has gone as high as ten dollars for each individual physician in the Association. Not only is the medical defense cheaper in Indiana but under the Indiana system the medical defense feature of our Association is functioning with absolute efficiency and from the year the medical defense feature was established until the present time not a single physician who was a member in good standing in the State Association, as required by the By-Laws on medical defense, and whose case was a legitimate one, has failed to receive defense from the State Society. A resume of the approximate amount of money received and expended in past years for medical defense follows:

Year	Receipts	Expenditures
1912	$ 1,883.25	$
1913	1,860.00	579.15
1914	1,963.50	1,140.75
1915	1,961.25	1,409.59
1916	1,926.00	1,688.57
1917	2,028.75	1,423.69
1918	1,370.25	888.57
1919	1,781.25	466.44
1920	1,834.50	794.00
1921	1,928.25	1,062.30
1922	1,941.00	315.00
1923	1,953.75	1,915.86
1924	1,859.75	340.00
1925	1,938.75	500.00
1926	1,995.75	337.50
1927	2,013.75	475.00
1928	1,989.00	1,650.00
	$32,228.75	$14,986.42

It will be noticed in this report that the total amount spent for defense during the current year is somewhat greater than in past years.

1. *Suggestions to members who apply for medical defense:*

(1) When threatened with a malpractice suit do not rush in and employ attorneys without first notifying headquarters office of your threatened suit.

(2) Fill out medical defense application blanks promptly and return to headquarters office just as soon as suit against you is filed.

(3) Let the medical defense committee make the final arrangements with the attorneys who are defending you.

(4) Keep the headquarters office posted as to developments in your case.

(5) Physicians must follow the regular routine method in applying for medical defense and must see to it that the executive committee is fully informed of the developments of the case, such as changes of venue, employment of associate attorneys, and the institution of new trials or appeals. This must be done in order that the executive committee may keep as absolute a check as possible upon the attorney fees which it may be expected to pay.

These suggestions are made as, in at least one case, a physician took the matter in his own hands, hired his attorneys, and sent the bill to the Association after the case was completed. The executive committee disapproves of such procedure and refused to take any step in this case which would establish such action as a precedent. No physician should expect medical legal defense from the Association if he takes it upon himself to manage the whole affair without consulting headquarters office.

2. *Suggested amendments to medical defense By-Laws.* During the year the executive committee was caused a good deal of embarrassment in coming to an agreement with the attorneys for fees charged in rendering services due to the fact that the physician who was sued made an agreement with the attorneys concerning such fees rather than leave this part up to the executive committee. In order that the committee may be protected in the future the following amendments to Chapter XII of the By-Laws of the Association are being suggested:

Add to Section 4 the following: And provided further that this Association shall not be liable for attorneys' fees in such suits unless this committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment including the fees to be paid.

Substitute for Section 7 the following as Section 7:

This Association shall not be liable for any damage awarded but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws.

3. *Detailed report of malpractice cases handled by medical defense committee.*

A year ago at the time of this report, August 1, 1927, the following 26 cases were pending before the committee and the committee reports the following progress of these 26 cases:

No. 107—Dropped.

No. 109—Dropped.

No. 122—Pending. Case filed August 1, 1923. Attorney for physician thinks case will be dropped eventually.

No. 123—Pending. Filed 1923. Case held up on demurr.

No. 125—Closed June 28, 1928. Jury returned verdict for plaintiff and damages for $1,500 in May, 1926. Motion made for new trial and motion overruled. Expenses—attorneys' fees:

December 12, 1924	$ 50.00
December 12, 1924	100.00
June 28, 1928	250.00
June 28, 1928	250.00
	$650.00
Paid in 1928	500.00

No. 126—Case apparently dropped.

No. 127—Case closed August 1, 1927. Tried 1925. Jury disagreed. Retried. Plaintiff obtained verdict for $2,500.00. Appealed June 9, 1927 Decision reversed. Expense — December, 1925—$100.00.

No. 128—Suit pending. Think case will be dropped soon.

No. 129—Suit pending.

No. 130—Closed January 7, 1928. Compromise for $100 in favor of plaintiff. Expense—January 14, 1928—$250.00.

No. 134—Suit threatened but not filed.

No. 136—Suit threatened but statute of limitations expired July 15, 1927.

No. 139—Claim pending.

No. 140—Suit pending. Filed February 1, 1926.

No. 141—Closed June 28, 1928. Tried May 19, 1927. Hung jury, ten for acquittal and two for conviction. New trial January 23 and January 30, 1928. Compromise verdict for $500.00 rendered. Cost—June 28, 1928—$750.00.

No. 142—Suit pending.

No. 143—Suit pending. Probably will be dismissed eventually.

No. 146—Claim pending. Dropped. Statute of limitations expired August 10, 1927.

No. 148—Claim threatened. Dropped because of no cause of action in same.

No. 149—Claim threatened July, 1926. Probably dropped.

No. 150—Closed. Suit filed September 20, 1926. Compromised and suit dropped. Cost for attorneys $150, February 17, 1928.

No. 151—Pending. Suit filed July, 1927.

No. 152—Judgment against plaintiff. Case pending in Appellate Court. Cost $100, June 23, 1927.

No. 153—Suit pending.

No. 154—Suit pending.

No. 155—Suit threatened.

Since August 1, 1927 to August 1, 1928, the following new cases have come before the committee:

No. 156—Suit filed March 27, 1928. Case pending.

No. 157—Suit filed February 8, 1928. Pending.

No. 158—Suit threatened January 11, 1928.

No. 159—Suit threatened May, 1928.

The total cost for medical defense during the year was $1,650. A report of the financial condition of the medical defense fund is contained in the treasurer's report.

4. Malpractice cases arising from insanity inquests. During the year two malpractice suits were referred to the committee arising from physicians who testified as witnesses in insanity inquests. Upon the request of the executive committee the attorney of the Association was asked for his opinion concerning the advisability of having a law passed to protect physicians from malpractice suits who were called to testify as witnesses in insanity inquests. The attorney for the Association said that in his judgment such a law would not be advisable and stated that *a physician does not have to testify before a justice of the peace unless he desires* and that *no contempt of court proceedings could be filed against a physician who refused to act as witness in an insanity inquest in a justice of the peace court.*

Respectfully submitted,

A. L. MARSHALL, Chairman,
DAVID ROSS,
GEORGE R. DANIELS,
WM. R. DAVIDSON,
ALBERT E. BULSON, JR.

REPORT OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

House of Delegates, Indiana State Medical Association:

Gentlemen:—The perfection of an effective state-wide organization to safeguard public health and to maintain the standards of the medical profession has been the principal object of your legislative committee in preparing for the 1929 session of the Indiana General Assembly and in playing its part during the session of Congress which has just closed. In order that the profession throughout the state may see at a glance what has and is being done by your committee, the report will be made under the following three headings:

I Organization.
II Local and state legislative activities.
III National legislation of interest to physicians.

I ORGANIZATION.

1. County legislative committees. County legislative committees have been appointed in fifty-five county societies. Twenty-seven county societies as yet have not reported the appointment of a legislative committee to headquarters.

2. District legislative committeemen. Each of the thirteen councilor districts has appointed a legislative committeeman who is responsible for legislative affairs in his district. These appointments are made according to a new plan of organization which was adopted this year.

3. Central committee. The state legislative committee forms the central committee for the Association.

4. District legislative meetings. District legislative meetings similar to the ones held in 1926 are to be held this year previous to the legislature. At these meetings the political situation in each county is reviewed and a check-up for the entire district is made.

5. Discrepancies between medical districts and congressional districts. A comparison of the medical districts and the congressional districts shows many discrepancies. However, sufficient similarity exists for the district councilor to appoint a district political chairman who, in turn, is responsible for each county in his congressional district.

II LOCAL AND STATE LEGISLATIVE ACTIVITIES.

1. We must be prepared to meet the attacks of cultists who will battle actively to break down the barriers which safeguard the public health with a flood of incompetent healers. Even now, in the face of the Briggs diploma mill expose, these various cults are preparing bills to be presented at the next legislature for the creation of separate drugless healing boards. For this reason it is absolutely necessary that the officers and members of your county societies know the attitude toward public health legislation of each legislative candidate for which he is to vote.

2. The platform upon which your committee will stand at the next legislature follows:

a. That all persons, classes, sects or cults, who pretend to recognize and treat human disease shall stand equal before the law.
b. That one fundamental educational standard be required of all who pretend to recognize and treat human disease. All should submit to the same license requirements.
c. That one board pass on the fundamental and professional qualifications of all persons seeking a license to permit them to offer their services to the public, as one skilled in the recognition and treatment of human diseases.
d. That nothing shall be written into the law which would in any way be construed as interfering with any method of treatment which any person who has complied with these principles might wish to employ.

3. Co-operation with the State Board of Medical Registration and Examination. Each individual physician should co-operate to the best of his ability with the State Board of Medical Registration and Examination with a view that the new provisions of the law be enforced. Each one should know the following facts concerning the enforcement of the Medical Practice Act and the administration of the law:

a. That the State Board of Medical Registration and Examination is supported by funds derived from physicians.
b. That it is not supported by taxation.
c. That it is limited by the State Budget Committee in using funds derived from the fees of candidates for licenseship.

Each county legislative committee should from time to time acquaint the members of the House of Representatives and the Senate of the Indiana General Assembly with the fact that money received by the State Board of Medical Registration and Examination for fees properly belongs to this Board and should be used by the Board in enforcing the law.

III NATIONAL LEGISLATION OF INTEREST TO PHYSICIANS

1. Narcotic Tax. Bills were introduced during the last session of Congress to increase the Harrison Narcotic Tax from $1.00 to $3.00 a year. This movement which would have cost every physician in Indiana an additional $2.00 a year, was defeated, Indiana congressmen and senators playing an active part.

2. Deduction of traveling expenses from income tax returns. Senator Arthur Robinson, of Indiana, introduced an amendment to the Revenue Reduction Bill authorizing physicians to deduct traveling expenses incurred in attending meetings of professional organizations. The amendment passed the Senate but was rejected by the House and lost in conference committee.

Respectfully submitted,

JOHN H. HEWITT, Chairman.
LOUIS E. FRITSCH,
O. T. SCAMAHORN.

REPORT OF COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

House of Delegates, Indiana State Medical Association:

Gentlemen:—The chairman of the Committee on Medical Education and Hospitals attended the meeting of the Association of American Medical Colleges at McGill University, Montreal, in October, 1927, and the meeting of the Council on Medical Education of the American Medical Association at Chicago this spring.

Among the interesting papers presented at Chicago was a "Survey of Nursing Education." This survey showed that with the rapid establishment and expansion of hospitals in the first quarter of this century, the number of training schools for nurses has been greatly increased and the size of established schools has also been greatly increased with the result that the number of nurses graduated each year is a number of times greater than a quarter of a century ago. In fact the number of graduates is so great that the demand is over-supplied. The reader of the paper clearly recognized the need of specialization in nurses' training. For the nurse who is merely a caretaker for a healthy baby, a six months training is adequate, while for the nurse who is to care for a pneumonia, specialization beyond the three years required for graduation is desirable. Since there is a great demand for nursing of the simpler sort, it seems clear that this demand should be met by a short period of training of a young woman who could afford to work for a weekly charge that would not be beyond the means of the great mass of people who have a moderate income.

The committee has functioned in its hospital relation by visitation, inspection and approval of a number of hospitals of the state as places desirable for interns or residencies. Other visits are to be made soon and prior to the meeting of the state society.

So far as medical education is concerned, the difficulty of the situation increases. The chairman of this

committee made a report at the meeting of the Association of American Medical Colleges in October, which showed that this last fall, 11,282 students applied 23,590 times for matriculation in the freshman year of medical schools of North America. Of this number 6,495 were accepted and 4,519 were refused, the disposition of 268 being undesignated. Of students who were refused the preceding year 1,339 reapplied of whom 750 were accepted and 589 were again refused. A year ago the Indiana University School of Medicine had 460 applications for freshman matriculation. This year at this time the number is approximately 600 but our capacity remains unchanged.

BURTON D. MYERS, Chairman,
S. E. EARP
WALTER MCFADDEN.

REPORT OF THE COMMITTEE ON CIVIC AND INDUSTRIAL RELATIONS

House of Delegates, Indiana State Medical Association:
Gentlemen:

The Committee on Civic and Industrial Relations has devoted its activities during the past several years solely to the industrial relations.

The policies of the committee were formed after a careful fact finding study was made. This study included all the elements entering into the problem. Questionnaires were mailed to employers in retail, wholesale and manufacturing; to insurance companies carrying industrial risks; to organized labor and to many doctors representing different parts of the state, city and country.

As a result of this study the committee assumed a quasi-judicial role or acted as arbitrator in cases where the insurance carrier and the doctor were unable to agree on the fee to be charged for the service rendered. A number of abuses had crept into the industrial surgical relationship. This resulted in mutual antagonisms and mutual distrust which the policy of the committee has helped to dissipate. It has been the self-imposed duty of the committee to defend proper and legitimate fees under all circumstances. This entailed by inference the boosting of inadequate fees and the trimming of excessive fees. The popularity of the committee has been greater in the first instance.

The field of usefulness can be very great if the committee retains the confidence of the profession. It is possible that many more members of the Association would make use of the good offices of the committee if they would but remember it existed. The committee is concerned solely that no member of the medical association lacks support in any contention with insurance carriers. This support, which carries with it the full influence of organized medicine, can be of great help in correcting abuses that may be perpetuated without it.

Respectfully,
FRANKLIN SMITH CROCKETT, Chairman.
W. D. NICHOLS, Hammond.
A. F. KNOEFEL, Terre Haute.

REPORT OF COMMITTEE ON POST-GRADUATE STUDY

House of Delegates, Indiana State Medical Association:
Gentlemen:—With regard to the report of the Committee on Post-Graduate Study, appointed by the Indiana State Medical Association for the year 1928, this committee is a continuance of the one appointed the previous year. The committee feels that its report handed in a year ago covered the field as far as the committee itself could go; consequently, we have nothing further to report this year other than a confirmation of our observation previously reported.

Very sincerely yours,
FLOYD H. ROMBERGER, M.D., Chairman,
C. NORMAN HOWARD, Warsaw,
LYMAN OVERSHINER, Columbus,
F. E. SAYERS, Terre Haute,
ALFRED S. JAEGER, Indianapolis.

REPORT OF DIPHTHERIA COMMITTEE

House of Delegates, Indiana State Medical Association:
Gentlemen:—In accordance with a resolution adopted by the House of Delegates two years ago, your Diphtheria Committee has co-operated with the State Board of Health, State Parent-Teachers Association, county medical societies, local welfare organizations and local health officials "with an effort to secure the widest possible use of toxin antitoxin in the prevention and control of diphtheria in the state of Indiana."

As this campaign of education has been to a large extent successful and as your committee believes it has accomplished its purpose, we herewith recommend the discontinuance of this committee as a permanent group.

If in the future necessity arises for further work along these lines we believe it can be handled by the Council and the Bureau of Publicity.

Signed,
JAMES H. STYGALL, Chairman,
DON MILLER,
WILLIAM STEMM.

REPORT OF COMMITTEE ON NECROLOGY

House of Delegates, Indiana State Medical Association:
Gentlemen:—Ninety-three of our comrades, friends, brothers and loved ones fell before the "Scythe of Time" during the year now entering the eternal past. A sad tale for your committee to relate, as it is a dreadful gain of fifteen over the preceding year, and the chairman had so hoped to show a substantial decrease in the harvest of the "Grim Reaper".

September 1927 led with fifteen as the same month last year led with ten. October, '27, was next with twelve; February, '28, totaled eleven; March had nine; December, '28, came in with eight while August of '27 and June of '28 each numbered seven; six each were recorded for January and May of '28; April five; November of '27 had four while July of '28 registered the lowest with only three.

Forty-six of the number were members of the Indiana State Medical Association. Forty-three were members of the A. M. A. and fourteen were Fellows of the American Medical Association.

Two had been presidents of the Indiana State Medical Association. Dr. G. W. H. Kemper in 1887 and Dr. John H. Oliver in 1917.

Several of the number had been writers of ability, foremost among them being Dr. Kemper, author of "The World's Anatomists", "The Uses of Suffering", and "A Medical History of Indiana". Dr. O. G. Pfaff was the author of many valuable contributions on the subject of gynecology. Dr. John Oliver wrote numerous articles on the various departments of surgery with which he was so familiar, and the writings and lectures of Dr. Frank A. Morrison are known to every doctor and medical student in the country. The outstanding men in the list are Dr. Kemper, Dr. Pfaff, Dr. Oliver, Dr. Morrison, Dr. Samuel E. Smith and Dr. Beall.

Two of the number were veterans of the Civil war, General W. H. Kemper and Dr. John L. Puckett, the latter of Kokomo, who was not only doctor but soldier, minister, mayor of his city, and city judge. He is said to have filled all these positions with distinction and credit.

Seventy of the physicians were graduates of allopathic schools; three had preferred physiomedical schools, five were eclectics and the school choice of the remaining fifteen could not be learned by the committee.

Cerebral hemorrhage led the list in causes of death with 17 victims. Bright's disease was a close second with 15 physicians; pneumonia claimed 12, while influenza and organic heart disease each took 10; 7 succumbed to arteriosclerosis; 4 each to accidents and senility; cancer and tuberculosis each had 3 and two fell under the stress of cholecystitis. Of the accidents, one was due to interurban collision; one resulted from a fall and two were

automobile catastrophies. The cause of death in the remaining 15 was unobtainable by the reporter.

The choice in medical schools follows: Medical College of Indiana, 17; Meharry Medical College of Nashville, 1; Curtis Physio-medical of Marion, 2; Physio-medical of Indianapolis, 1; University of Louisville, 7; Rush, 3; Miami, 4; Medical College of Ohio, 8; Eclectic, 5; University of Pennsylvania, 1; Evansville, 1; Trinity of Toronto, 1; University of Kentucky, 4; Jefferson Medical, 2; University of Michigan 1; Fort Wayne, 3; P. and S. of Baltimore, 1; Western Reserve, 1; University of Chicago, 4; Detroit Medical College, 1; Bennett of Chicago, 1; Cincinnati College of Medicine, 1; Long Island, 1; P. and S. of Indianapolis, 2, and St. Joseph's Medical College, 1. The choice of schools for the remaining 19 doctors is not known to the writer.

The oldest physician of the number was Dr. Kemper, who died at his home in Muncie, September 26, 1927, at the age of eighty-six years. The youngest one to pass away was Dr. Benjamin F. Beavers, of Decatur, who died April 2, 1928, at the age of thirty-seven.

The age periods were: 30 to 40, one death; 40 to 50 took 9; 50 to 60 had 19; 60 to 70 claimed 33; 70 to 80 totalled 23 and the decade of 80 to 90 finished the list with 8. The combined ages of these physicians was 6,142 years or an average age of 66 1/3 years as against 67½ years of last year.

REPORT OF COUNTY SECRETARIES CONFERENCE

House of Delegates, Indiana State Medical Association:

Gentlemen:—As the name implies our organization is a County Secretaries Conference, the purpose being the getting together of the County Secretaries, for an exchange of plans and ideas, a discussion of some of our problems and to be a mutual help and benefit to the other.

We have had during the year one meeting of the executive committee composed of five county secretaries with the chairman, and our meeting on April 26, which we voted to make our annual meeting.This meeting was a dinner meeting at Indianapolis with a representative attendance of the following:

Joseph L. Allen, Greenfield, Hancock county.
M. A. Austin, Anderson, Madison county.
J. C. Burkle, Lafayette, Tippecanoe county.
C. E. Boyd, West Baden, Orange county.
O. G. Brubaker, North Manchester, Wabash county.
E. R. Clarke, Kokomo, Howard county.
I. E. Carlyle, Sedalia, Clinton county.
M. B. Catlett, Fort Wayne, Allen county.
D. S. Conner, Cannelton, Perry county.
Wm. A. Doeppers, Indianapolis, Marion county.
C. E. Gillespie, Seymour, Jackson county.
Max Gitlin, Bluffton, Wells county.
H. E. Grishaw, Tipton, Tipton county.
J. K. Hawes, Columbus, Bartholomew county.
G. E. Iterman, Newcastle, Henry county.
W. T. Lawson, Danville, Hendricks county.
D. L. McAuliffe, North Vernon, Jennings county.
M. A. McDonald, Peru (substitute for secretary, E. H. Andrews, of Peru), Miami county.
R. G. Moore, Vincennes, Knox county.
A. M. Mitchell, Terre Haute, Vigo county.
E. R. Mason, Bloomfield, Greene county.
S. T. Miller, Elkhart, Elkhart county.
H. C. O'Dell, Sullivan. Sullivan county.
T. R. Owens, Muncie, Delaware-Blackford county.
E. E. Padgett, Indianapolis (Councilor, Seventh dist.)
Allen Pierson, Spencer, Owen county.
A. L. Spinning, Covington, Fountain-Warren county.
P. H. Schoen, New Albany, Floyd county.
C. A. Stayton, Indianapolis, Marion county.
A. E. Steinson, Athens, Fulton county.
R. W. Shanks, Noblesville, Hamilton county.
V. L. Turley, Fowler, Benton county.
O. A. Turner, Madison, Jefferson county.

The following program was taken up:

County Society Programs (material type of programs, etc.)—J. C. Burkle, M.D., Tippecanoe county, and R. G. Moore, M.D., Knox county.

Membership Problems (collection of dues, solicitation of members, best way of getting word to members, etc.)—T. R. Owens, M.D., Delaware-Blackford, and A. M. Mitchell, M.D., Vigo counties, discussants.

Meetings (relative value of dinner meetings, joint meetings and meetings with other professional groups, such as dentists, lawyers, etc.)—W. T. Lawson, Danville.

Economics (fee for industrial cases, medical witness fees, expert testimony, etc.)—P. H. Schoen, M.D., Floyd county.

Social Activities in County Societies (functions, dinners, mixed meetings, Women's Auxiliary)—C. A. Stayton, M.D., Indianapolis Medical Society, and M. B. Catlett, M.D., Fort Wayne.

A very interesting discussion followed the dinner and much valuable information was presented and we are sure many helps offered for planning and carrying out programs and meetings for the next year. We were very sorry some of our members were not with us. We hope they will gain some benefit from the reports in THE JOURNAL as they appear from time to time.

While we have not reached our goal for the year as yet, we think we have made a fair start, and that the results may grow by discussions among our secretaries and members of the County Societies. Pass the good thing along. We have started a general interest that it may reach every individual in due time.

Realizing that the secretary is the most valuable person in a County Medical Society we suggest the following, among others, to be set as a goal for next year. 1. Elect a live man for secretary and work with him; 2. Secure a Secretary's page in THE JOURNAL for regular reports of proceedings and comments. 3. Each Secretary to be responsible for articles and reports by himself or other members of his Society getting into the page. 4. A more general visiting of sister societies by officers and members of the various societies and a taking part in the social and scientific programs. 5. Plan definitely to attend the national, state and county meetings of medical men with exchange of ideas. 6. Always have an open mind.

Frequent communication with the state secretary and a prompt attention to your correspondence of a medical nature is necessary. If you have a good thing or meeting in your county, report it to THE JOURNAL that others of us may receive benefits also. Make the state meeting the big thing at the end of the year and the annual meeting of county secretaries in April the big mid-year meeting.

We desire to thank the officers of the State Medical Association and Dr. Bulson, editor of THE JOURNAL for their loyal support during this year and we promise you better things for next year.

Committee,
J. C. BURKLE, M.D., Chairman,
A. M. MITCHELL,
E. M. SHANKLIN,
C. A. STAYTON,
THOMAS OWENS,
HARRY P. ROSS.

REPORT OF THE BUREAU OF PUBLICITY

House of Delegates, Indiana State Medical Association:

Gentlemen:—

I. INTRODUCTION.

In presenting the sixth annual report of the Bureau of Publicity of the Indiana State Medical Association, the members of the Bureau wish to express their very sincere appreciation of the cordial approval of the Bureau's work that has come from the profession both inside and outside the state.

In previous reports the Bureau has outlined in detail its general line of procedure and its routine duties. In this report the Bureau takes it for granted that the profession is acquainted with its methods and has confined itself to a brief outline of its activities during the past year.

II. NEWS NOTES FOR THE JOURNALS.

Starting in March the Bureau supplied a number of notes of current medical interest to the *Journal of the American Medical Association* which appeared from week to week in the Indiana column and also to THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION which have appeared regularly in its issues. The Bureau will appreciate receiving notes which might be suitable for these publications from Indiana physicians or medical organizations.

III. BUREAU ACTS AS COMMITTEE BETWEEN INDIANA STATE MEDICAL ASSOCIATION AND PUBLIC HEALTH GROUPS.

Under authority of a resolution passed by the House of Delegates at the 1927 session of the Publicity Bureau was instructed to "act as a special committee to confer with similar committees appointed by voluntary health agencies on matters pertaining to the work of these public health organizations and their relation to the medical profession." In accordance with this authority, early in the year a conference was held with a committee from the Indiana Tuberculosis Society and co-operation given the "Early Diagnosis Campaign" of the National Tuberculosis Association at which many suggestions of vital interest to both organizations were brought forth.

IV. REQUESTS FOR HELP OF THE BUREAU FROM OUTSIDE SOURCES.

During the past year numerous requests have been received from outside of Indiana asking for copies of articles previously prepared and released by the Bureau. In addition to such requests and numerous Bureau articles which have appeared in papers outside Indiana, requests have come for articles from the Secretary of the Minnesota State Medical Society, the Louisiana State Medical Association, the West Virginia State Medical Society, the Maine State Medical Association, and from Berlin, Germany.

V. AID TO THE COUNTY SOCIETIES.

The Bureau of Publicity is always ready and willing to be of aid to county medical societies and throughout the year has helped get speakers and make other arrangements for county medical society meetings. Not only will the Bureau supply a speaker for a county society meeting when requested, but working in co-operation with the officers of the county medical society the Bureau will see that notice of this meeting is received by the members of the county medical society.

VI. MEDICAL FRAUDS.

1. Cancer Quacks and "Specialists". The Bureau of Publicity during the year received several appeals from persons who had been defrauded by cancer quacks and other charlatans. The Bureau investigated each of these cases thoroughly and in co-operation with the Bureau of Investigation of the American Medical Association, and the Better Business Bureau of Indianapolis received an adjustment of the bill in one case for a patient who had been defrauded by a quack doctor.

Most frequent among these persons who appeal to the Bureau are those who have paid out large sums of money to cancer quacks. In these cases the "Cancer Specialist" usually asks the patient to sign a contract and pay in advance. The contract is usually signed by the patient who does not read it carefully after the verbal assurance by the quack doctor that the contract is all right.

These contracts generally carry a clause which is guarded but in very definite term carries a phrase that a cure is not guaranteed. If the attention of the so-called doctor is called to the paragraph in question, the specialist is quick to explain that such a clause is put in the contract as "some cases are not curable." At the same time this commercial physician makes it appear as if the patient who is applying for treatment may expect a sure cure. It is a pathetic story that victims of these charlatans tell to the Bureau of Publicity. Besides helping these patients the Bureau has issued for the public press special warning against the Koch cancer "cure" and other cancer "cures".

2. The Bureau again wishes to stress its warning of last year against the "health" articles by "Doctor" Frank McCoy, a drugless healer of California who is conducting a health column in several of the papers of the state. Physicians whose local newspapers are handling the McCoy syndicated articles should take this matter up with the editors of the newspapers and tell them the facts concerning McCoy. These facts may be obtained from the Bureau of Publicity.

3. Radium Jugs. Through the Bureau of Investigation of the American Medical Association the Bureau of Publicity obtained information upon Radium Ore Revigator, a "radium" jug which is being sold to the public and is said to be capitalizing the public's lack of knowledge of radium and radium activity. This information was forwarded to the editor of a newspaper requesting it.

VII THE COMMITTEE ON THE COST OF MEDICAL CARE.

The Bureau reviewed the pamphlet received from the Committee on the Cost of Medical Care and suggested that the physicians throughout the state give their heartiest co-operation to the work of this committee.

VIII. REPORT PREPARED BY THE BUREAU OF PUBLICITY ESPECIALLY FOR THE ANNUAL CONFERENCE OF SECRETARIES OF CONSTITUENT STATE MEDICAL ASSOCIATIONS WHICH MET AT CHICAGO IN 1927.

In this report the Bureau of Publicity outlined the various activities and method of management of the Indiana State Medical Association. At the request of the Secretary of the American Medical Association, this report was prepared for use at this conference.

IX. DISTRIBUTION OF WEEKLY NEWSPAPER RELEASES.

Weekly releases are distributed as follows:

1. 200 to Indiana newspapers.
2. 700 sent to Parent-Teachers Association. This is an increase of 200 releases over last year, 6 of which go to the Indiana University Package Library service.
3. 50 sent to the Indianapolis W. C. T. U.
4. 100 sent to public health nurses through the nursing division of the Indiana State Board of Health.

Beside the regular newspaper releases the Bureau of Publicity distributed to the press a statement of the Secretary of the State Board of Medical Registration and Examination in regard to the administration of the new amendment to the Medical Practice Act. This was done in accord with a resolution adopted by the House of Delegates authorizing the Bureau of Publicity to disseminate information covering the full facts concerning the enforcement of the Medical Practice Act and the administration of the law by the Indiana State Board of Medical Registration and Examination.

1. That the State Board is supported by funds derived from physicians.
2. That it is not supported by taxation.
3. That it is limited by the State Budget Committee in using funds derived from the fees of candidates for licenseship.

In addition to the statement to the press upon this subject the Bureau suggests that every physician in Indiana at once and from time to time acquaint the members of the Indiana House of Representatives and the Senate with the fact that money received by the State Board of Medical Registration and Examination for fees properly belongs to this Board and should be used by the Board in enforcing the law. Legislators should be appealed to by all physicians that the State Board of Medical Registration and Examination should be allowed to use the

money paid to it by physicians in the way the Board sees fit. The Bureau feels that the Board should not be limited by the Budget Committee in the use of these funds as these funds are collected not from the public *but from the physicians themselves,* being paid in by physicians who take their examinations for licenses and by reciprocity fees.

X. LIST OF NEWSPAPER RELEASES FOR 1927-1928.

Typhoid Fever.
The Fourth "R"—Robustness.
Infantile Paralysis.
Announcement of Board of Medical Registration and Examination.
Hoosierland's Health Harvest.
Neuralgia.
Thanksgiving Greetings.
Anthrax.
Nature Curing or Physical Therapy.
Cigarette Advertisements.
The Conquest of Disease.
Holiday Health.
Health Resolutions.
Cancer Cures.
Periodic Health Examination, Article I.
Annual Health Audits, Article II.
Why Periodic Health Examinations, Article III.
Periodic Health Examinations and Early Diagnosis of Tuberculosis, Article IV.
Early Diagnosis of Tuberculosis, Article V.
Basketball in Indiana.
Spring Tonics.
Mal de March.
Practical Psychoanalysis and Health.
Spring Cleaning.
May Day.
Ill Health in Your City.
Prevent Hay Fever Now.
Some Facts About Yeast.
Vacations and Typhoid Fever.
Summer Care of Young Children.
A Modern July Fourth.
Sunshine.
Sunstroke.
Chiggers.
Protection Against Typhoid Fever.

XI. RADIO RELEASES.

The following releases have been broadcast.
Annual Health Examinations.
Prevent Hay Fever Now.
Some Facts About Yeast.
A Modern July Fourth.
Sunshine.
Sunstroke.
Chiggers.
Summer Care of Young Children.
Children and Fear.
Hot Weather Health Hints.
Safe and Sensible Swimming.
Protection Against Typhoid Fever.

Beginning on June 9, 1928, the Bureau of Publicity prepared weekly releases for Station WFBM, Indianapolis Power and Light Company station. These releases are in the form of ten-minute talks each Saturday night and are prepared by the Bureau but read by a trained radio announcer. The policy of the Bureau in not using a physician's name in the newspaper articles is carried out in these radio talks.

In addition to the regular weekly radio ten-minute talks the Bureau of Publicity prepared, upon request, a series of seven five-minute talks which were broadcast the week preceding Child Health Day, May 1. The name of no Indiana physician was mentioned in broadcasting these talks. These talks were largely upon the value of diphtheria immunization and vaccination.

XII. SPECIAL SERIES OF PERIODIC HEALTH EXAMINATIONS.

In co-operation with the "Early Diagnosis Campaign" of the Indiana Tuberculosis Society, the Bureau of Publicity released the following four articles upon the value of periodic health examinations:

Article 1—Periodic Health Examinations.
Article 2—Annual Health Audits.
Article 3—Why Periodic Health Examinations?
Article 4—Periodic Health Examinations as a Means for the Early Discovery of Tuberculosis.

Each of these articles was reprinted in THE JOURNAL.

These articles have been specially noted and favorably commented on by the Bureau of Health and Public Instruction of the American Medical Association.

XIII. SPEAKERS WERE SUPPLIED BY THE BUREAU FOR THE FOLLOWING PUBLIC AND MEDICAL MEETINGS IN 1927-1928:

1927.
Oct. 20—Eleventh District Medical Meeting, Delphi, Indiana.
Oct. 26—Tri-County Medical Society, North Vernon Indiana.
Nov. 15—Morristown Community Club, Morristown, Indiana.
Nov. 18—Decatur County Medical Society, Greensburg, Indiana.
Dec. 13—Knox County Medical Society, Vincennes, Indiana.

1928.
Jan. 17—Parent-Teachers Association, North Manchester, Ind.
Jan. 24—Johnson County Medical Society, Franklin, Indiana.
Jan. 25—Tri-County Medical Society, North Vernon, Indiana.
Jan. 27—Hendricks County Medical Society, Danville, Indiana.
Feb. 6—Fountain-Warren County Medical Society, Veedersburg, Ind.
Feb. 7—Kiwanis Club, Cambridge City, Ind.
Feb. 16—Cass County Medical Society, Logansport, Indiana.
Feb. 27—Jefferson County Medical Society, Madison, Indiana.
Mar. 5—Rush County Medical Society, Rushville, Ind.
Mar. 6—Jackson Township School, Rushville, Ind.
Mar. 8—Parent-Teachers Association, Pittsboro, Ind.
Mar. 13—Knox County Medical Society, Vincennes, Indiana.
Mar. 13—Center Township, Rushville, Ind.
Mar. 13—Rotary Club, Madison, Ind.
Mar. 22—Crawfordsville Kiwanis Club, Crawfordsville, Indiana.
Mar. 29—Cass County Medical Society, Logansport, Indiana.
Apr. 10—Knox County Medical Society, Vincennes, Indiana.
May 10—Third District Medical Society, Orleans, Ind.
June 19—Sheridan Rotary Club, Sheridan, Ind.
July 13—Carroll County Medical Society, Rockfield, Indiana.
July 26—Laporte Kiwanis Club, Laporte, Ind.
July 30—Greenwood Lions Club, Greenwood, Ind.

XIV. FINANCIAL REPORT.

The expenditures of the Bureau from August 1, 1927, to August 1, 1928, follow:

Postage	$144.80
Clipping service	60.22
Stationery and office supplies	118.15
Stencils and mimeograph supplies	119.22
Speakers' expense	20.88
Telephone and telegraph tolls	.35
Two years' subscription to Hygeia	6.00
Total expense	$469.62

The Bureau was allowed by the Budget Committee $750.00 for the year of 1928. Of this amount the committee has spent $327.38 from January 1 to August 1, 1928, leaving a balance of $422.62 unexpended in the budget for the remainder of 1928.

XV. SCIENTIFIC EXHIBIT AT THE ANNUAL MEETING.

In connection with the re-establishment of the scientific exhibit at the annual meeting the Bureau wishes to make the following brief historical comment:

The first scientific exhibit at an American Medical Association meeting was made by the late Frank B. Wynn, M.D., in June, 1897, at the Columbus, Ohio, meeting. This exhibit reproduced and enlarged an exhibit previously made at the state meeting of the Indiana Association. The exhibit at the Indiana State Medical Association had resulted from the accumulation by Dr. Wynn of interesting pathological specimens on "case night" which was held each month by the Indianapolis Medical Society. Dr. Wynn, with co-operation of the president of the Indiana State Medical Association and the assistance of physicians throughout the state, presented an interesting exhibit at the American Medical Association meeting consisting of pathological specimens and unusual cases. The exhibit was held in a vacant storeroom near the meeting place of the Association at Columbus. So much interest was developed in the exhibit that it was adopted as an annual feature of the American Medicalcal Association meetings and a special committee, of which Dr. Wynn was chairman, was appointed. There was soon added to the pathological exhibit other exhibits of scientific interest. The name of the exhibit was subsequently changed from the pathological exhibit to the scientific exhibit. Dr. Wynn served as chairman of this exhibit committee for several years when he finally resigned. His enthusiasm was so great for this work that Dr. W. W. Keene, president of the American Medical Association, two or three years after the establishment of the exhibit spoke of Dr. Wynn as "the devoted prisoner of the pathological exhibit."

Respectfully submitted,
WM. N. WISHARD, M.D., Chairman.
MURRAY N. HADLEY,
J. A. MCDONALD.

REPORT OF DELEGATES TO THE A. M. A.

House of Delegates, Indiana State Medical Association:

Gentlemen:—The delegates to the A. M. A. respectfully refer you to the report concerning the activities of the Minneapolis session of the American Association as printed in the July number of THE JOURNAL. We, therefore, deem it unnecessary to duplicate that report. Your delegates were faithful in attendance and all were represented in some way or other upon important committees of the A. M. A.

Respectfully submitted,
ALBERT E. BULSON, JR., Fort Wayne,
DAVID E. ROSS, Indianapolis,
HARRY ELLIOTT, Brazil,
E. M. SHANKLIN, Hammond.

LIST OF PRESIDENTS OF THE INDIANA STATE MEDICAL ASSOCIATION SINCE ITS ORGANIZATION

Names and Residences	*Elected*	*Served*
Livingston Dunlap, Indianapolis	1849	1849
William T. S. Cornett, Versailles	1849	1850
Asahel Clapp, New Albany	1850	1851
George W. Mears, Indianapolis	1851	1852
Jeremiah H. Brower, Lawrenceburg	1852	1853
Elizur H. Deming, Lafayette	1853	1854
Madison J. Bray, Evansville	1854	1855
William Lomax, Marion	1855	1856
Daniel Meeker, Laporte	1856	1857
Talbott Bullard, Indianapolis	1857	1858
Nathan Johnson, Cambridge City	1858	1859
David Hutchinson, Mooresville	1859	1860
Benjamin S. Woodworth, Fort Wayne	1860	1861
Theophilus Parvin, Indianapolis	1861	1862
James F. Hibberd, Richmond	1862	1863
John Sloan, New Albany	1863	1864
John Moffet (acting) Rushville	1864	1864
Samuel M. Linton, Columbus	1864	1864
Myron H. Harding, Lawrenceburg	1865	1865
Wilson Lockhart (acting), Danville	1865	1866
Vierling Kersey, Richmond	1866	1867
John S. Bobbs, Indianapolis	1867	1868
Nathaniel Field, Jeffersonville	1868	1869
George Sutton, Aurora	1869	1870
Robert N. Todd, Indianapolis	1870	1871
Henry P. Ayres, Fort Wayne	1871	1872
Joel Pennington, Milton	1872	1873
Isaac Casselberry, Evansville	1873	1874
Wilson Hobbs, Knightstown	1873	1874
Richard E. Haughton, Richmond	1874	1875
John H. Helm, Peru	1875	1876
Samuel S. Boyd, Dublin	1876	1877
Luther D. Waterman, Indianapolis	1877	1878
Louis Humphreys, South Bend	1878	
Benj. Newland (acting), Bedford (v-p)	1878	1879
Jacob R. Weist, Richmond	1879	1880
Thomas B. Harvey, Indianapolis	1880	1881
Marshall Sexton, Rushville	1881	1882
William H. Bell, Logansport	1882	1883
Samuel E. Munford, Princeton	1883	1884
James H. Woodburn, Indianapolis	1884	1885
James S. Gregg, Fort Wayne	1885	1886
General W. H. Kemper, Muncie	1886	1887
Samuel H. Charlton, Seymour	1887	1888
William H. Wishard, Indianapolis	1888	1889
James D. Gatch, Lawrenceburg	1889	1890
Gonsolvo C. Smythe, Greencastle	1890	1891
Edwin Walker, Evansville	1891	1892
George F. Beasley, Lafayette	1892	1893
Charles A. Daugherty, South Bend	1893	1894
Elijah S. Elder, Indianapolis	1894	1895
Charles S. Bond (acting), Richmond	1894	1895
Miles F. Porter, Fort Wayne	1895	1896
James H. Ford, Wabash	1896	1897
William N. Wishard, Indianapolis	1897	1898
John C. Sexton, Rushville	1898	1899
Walker Schell, Terre Haute	1899	1900
George W. McCaskey, Fort Wayne	1900	1901
Alembert W. Brayton, Indianapolis	1901	1902
John B. Berteling, South Bend	1902	1903
Jonas Stewart, Anderson	1903	1904
George T. MacCoy, Columbus	1904	1905
George H. Grant, Richmond	1905	1906
George J. Cook, Indianapolis	1906	1907
David C. Peyton, Jeffersonville	1907	1908
George D. Kahlo, French Lick	1908	1909
Thomas C. Kennedy, Shelbyville	1909	1910
Frederic C. Heath, Indianapolis	1910	1911
William F. Howat, Hammond	1911	1912
A. C. Kimberlin, Indianapolis	1912	1913
John P. Salb, Jasper	1913	1914
Frank B. Wynn, Indianapolis	1914	1915
George F. Kieper, Lafayette	1915	1916
John H. Oliver, Indianapolis	1916	1917
Joseph Rilus Eastman, Indianapolis	1917	1918
William H. Stemm, Vernon	1918	1919
Charles H. McCully, Logansport	1919	1920
David Ross, Indianapolis	1920	1921
William R. Davidson, Evansville	1921	1922
Charles H. Good, Huntington	1922	1923
Samuel E. Earp, Indianapolis	1923	1924
E. M. Shanklin, Hammond	1924	1925
C. N. Combs, Terre Haute	1925	1926
Frank W. Cregor, Indianapolis	1926	1927
George R. Daniels, Marion	1927	1928

LIST OF EXHIBITORS

Frank S. Betz Company, Hammond, Indiana.
Britesun, Inc., 1115 North Franklin Street, Chicago, Illinois.
Central Pharmacal Company, Seymour, Indiana.
Columbus Pharmacal Company, Columbus, Ohio.
Deshell Laboratories, Inc., Chicago, Illinois.
H. G. Fisher & Company, 2333-43 Wabash Avenue, Chicago, Illinois.
Hoosier Pharmacal Company, Indianapolis, Indiana.
Kellogg Company, Battle Creek, Michigan.
Lederle Antitoxin Labs., 511 5th Ave., New York.
Medical Protective Company, Fort Wayne.
Mellin's Food, Boston, Massachusetts.
Pitman-Moore Company, Indianapolis, Indiana.
W. B. Saunders Company, Philadelphia, Pa.
Standard X-Ray Company, 1932 N. Burlington St., Chicago, Illinois.
Swan-Myers Company, Indianapolis, Indiana.
Tailby-Nason Company, Cambridge, Massachusetts.
Cameron Surgical Co., Chicago.
Meade-Johnson Co., Evansville.
Hanovia Chemical and Mnfg. Co., Newark, N. J.
Kny Scheerer Corporation, New York.
Akron Surgical House, Indianapolis.
Horlick's Malted Milk Company, Racine, Wisconsin.
Acme International Sales Company, Chicago.

THE PHYSICIAN'S INVESTMENTS

(Continued from page 378)

capable man of experience is a great mistake and usually a sad one. In discussing the matter with your banker there are several requirements, in fact you might say there are five standard requirements, to be considered in the purchase of any security. They are:

(1) Security (Safety of principal and interest);

(2) Income (Earnings);

(3) Marketability (Demand);

(4) Possibility of Appreciation (Increase in price);

(5) Stability (Sound, very little fluctuations in price).

Along with these requirements the physician should always diversify, that is, buy securities of different kinds of business. You have all heard the homely expression, "Don't place all your eggs in one basket." That is good as far as it goes and is perfectly true, particularly in the investing of money, but it should further say, "Then watch the eggs and the basket." Distribute your dollars among a fair number of issues but always good securities. To invest in the bonds or stocks of many companies, both good and questionable, is not the diversification policy of investment, it is merely diversification of risk. It is not so important whether you invest in securities of a railroad company, an industrial corporation or a public utility corporation as it is in the securities of companies which have long records of steady growth and continuous payments of interest and dividends.

Be careful, Doctor! Don't be the gullible investor ready to take the glib talk of the high pressure salesman, or the high sounding statements which you will find in some advertisements and circulars. Avoid all unlisted inactive stocks, especially those of new companies when advertised broadcast to sell at a low price—as being safe and to yield a high rate of interest. If there are any securities of such a nature which are really good and pay the high rates, they are not advertised. They are closely held or have been gobbled up. It is a miracle when a good thing gets by the large investing organizations which are combing the country with fine toothed combs in the interest of men of large means.

I recall an instance of a famous surgeon who came to a large investment banker relative to the securities he held, stating that for many years he had enjoyed a large income but that his investments had been unfortunate. After many years he found that he had a comparatively small amount of money saved. The banker, on analyzing the surgeon's securities or holdings, found that they consisted mostly of stocks in mining companies, oil companies, land development companies, irrigating projects, together with securities of companies organized to promote new patents "which the world had long been waiting for." Practically all of his money has gone to new companies and untried propositions.

I know from experience in checking the lists of holdings of many physicians that a large number of those physicians are buying or have bought wildcat stocks. It is a well known fact that the "sucker lists" always include the doctors, and it always has been a conundrum to the reputable investment banker why that should be so. Here is a class of men far above the average in intelligence, in rearing, training, education, character and culture who still fall for "low-brow" securities. If any among you physicians who read this article will explain the reason why, you will solve a riddle with a long unknown answer. However, I will say this, that during the past few years many physicians are becoming wise to the fact that it is better to have a $1,000 five per cent bond in a safe deposit box, and paying $25 every six months, than it is to have a wildcat stock certificate of par value of $10,000, purchased with one thousand good dollars, and a dividend *maybe*.

When an individual is ill he consults a physician. When a physician requires legal services he consults an attorney, and when he is building a home he goes to an architect, but why in the name of common sense does he not consult a banker when he wishes to invest his hard earned dollars?

The next time you have $100, $500, $1,000 or more, go to your banker and let him help you invest it. On the other hand get rid of the wildcat high pressure stock solicitor. Throw in your waste paper basket the startling advertisements and circulars guaranteeing you a stock which pays ten per cent per annum and doubles your principal

within a year. Don't feel that you have to wait until you have a thousand dollars to invest before consulting your banker. The experience which one of your well known Indiana associates related to me will bear out this truth. Many years ago he called at his bank to withdraw money to pay a second installment on a highly speculative stock which promised a high rate of interest. The cashier said, "Doctor, why do you buy such stock?" The physician answered, "I have very little money. I wish to get as much return as possible. I bought it on the recommendation of a stock salesman because I can pay for it on the installment plan." The banker then named a stock of real merit and said, "I will pick up a thousand dollars worth of it and when you have saved two hundred dollars come in and I will accept it as the initial payment and loan you eight hundred dollars on a note which can be renewed every ninety days until you have the stock paid for." And such is the policy he has followed all these years, always being able to borrow funds on his collateral.

And further, this man learned three things:

(a) To buy securities of merit;

(b) That he can purchase them on installment payments through his banker;

(c) That when a man is in debt to his bank he has the power to turn down high pressure stock salesmen.

Today this man has one of the cleanest lists of holdings I have ever analyzed. He has an established credit at his bank and among merchants. He is no longer on the "sucker list." He has not for years even been solicited to purchase that class of security. Your banker will be just as ready to serve you. He will give you trustworthy advice, and he will aid you in creating an estate. It is his business to prescribe for your financial ills as you prescribe for his physical ills. You will be happier, and richer in this world's material goods if you make him your financial physician and follow his advice.

PRESENT STATUS OF OVARIAN THERAPY

Great as have been the advances of the past few years in knowledge of the physiology of reproduction, says Emil Novak, Baltimore (*Journal A. M. A.*, September 1 1928), it cannot be said that they have as yet added very notably to the therapy of conditions dependent on disorders of ovarian function. The newer knowledge, however, offers a clear explanation of the failure of the ovarian therapy of past years, and, for the first time, justifies the hope that before long some at least of these functional disorders will be amenable to organotherapeutic measures. The question as to the singleness or duality of the ovarian secretion is still undecided, although, in the author's judgment, the evidence indicates that the follicle and corpus luteum hormones are not the same, and that both play important parts in the human sex cycle. This factor, even more than that of inadequate dosage, is probably responsible for the unsatisfactory results achieved from the employment of the follicle hormone itself. For this reason, it is more logical to combine with it the use of corpus luteum extract, imitating the sequence believed to occur in the normal sex cycle. One of the problems still to be solved, in spite of the encouraging results achieved by individual workers, is that of preparing a potent corpus luteum extract. The standards of potency are, of course, very different from those of the follicle hormone, a fact which some workers appear to overlook. Both from a clinical and laboratory standpoint, the evidence indicates that the oral administration of ovarian, corpus luteum and ovarian residue extracts has little or no value in the treatment of such objective disorders as amenorrhea. In the treatment of the characteristic vasomotor symptoms of the menopause, there is much evidence, though necessarily only clinical, that oral therapy is of value. While the hypodermic administration of the newer extracts is, on the basis of undisputed laboratory investigations, without doubt the method to be preferred, it possesses serious practical disadvantages which will almost certainly limit its applicability very materially. The disadvantages, enumerated in the paper, are enhanced for the present by the comparative scarcity of potent extracts and their rather considerable cost. As the ovarian follicle hormone at least possesses a slight effect when administered orally (not more than one-twentieth the hypodermic effect), it is not impossible that some form of satisfactory oral therapy may yet be developed, either by developing new sources of supply or by increasing the potency of the substance by some artificial means. This would be a contribution of real importance. Recent investigations, which demonstrate the profund effect produced on ovarian function by repeated implantations of anterior pituitary gland tissue, led to the hope that future work along this line may yield some method of applying this new knowledge therapeutically.

CISTERNAL AND LUMBAR PUNCTURE

A comparative study of cisternal and lumbar fluids in syphilis made by Harry C. Saunders and Leo Spiegel, New York (*Journal A. M. A.*, September 1, 1928) shows slight differences in cell count globulin reaction and colloidal gold reaction. It shows practically no difference in the Wassermann reaction. The interpretation of a spinal fluid analysis must not be based on a single finding, but on the results of the four tests in conjunction with the clinical examination.

PAY US

The rose is red,
The violet blue;
This little bill
Is overdue.
So pay it now—
Don't wait till when
The rose and violet
Bloom again.
For if you do
Delay it thus,
No violet
Will bloom for us.
Unless you pay,
The rose will rest
Upon our fair
And manly chest.
The birds will sing,
But what of that?
We shall not hear them
Where we're at.
So come across;
We need the dough
Not in the spring
But now, you know.
The rose is red,
The violet blue;
Do we need cash?
I'll say we do!

—*International Journal of Medicine and Surgery*, February, 1928.

THE JOURNAL
of the
Indiana State Medical Association
Devoted to the Interests of the Medical Profession of Indiana
Albert E. Bulson, Jr., B.S., M.D., F.A.C.S.
Editor and Manager

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EDITORIALS

OUR PRESIDENT

Dr. George R. Daniels, president of the Indiana State Medical Association for 1928, was born at Sweetser, Indiana, the son of Dr. George W. Daniels and Theresa L. Daniels. "George," as he is familiarly known all over the state, descended from a long line of Hoosier physicians, and has lived and practiced medicine in his home county almost all his life. He was educated in the public schools of Sweetser and Marion, Indiana, and graduated from the Medical College of Indiana, Indianapolis, in 1900. Upon the completion of his medical education he began the practice of medicine with his father at Sweetser, and it was not until March, 1904, that he moved to Marion where he since has been located.

From the earliest days of his practice Dr. Daniels has been interested actively in the functions and affairs of the Indiana State Medical Association, and this statement is proved by the fact that he never has missed an annual session of the Association since his graduation from medical school. He has been a regular attendant at his county and district medical society meetings, and has represented the Grant County Medical Society at almost every session since he started his practice. He has served as president of the Eleventh District Medical Society, and also served for a number of years on the Medical Defense Committee of the State Association. Despite his general interest in the affairs of the Association he says that the work which has lain closest to his heart has been that done as a member of the Legislative Committee of the Association in past years.

Dr. Daniels always has taken an active interest in public affairs of his community, and was elected mayor of Marion on the Republican ticket, serving from 1922 to 1926. During this time, (1925) a very successful session of the Indiana State Medical Association was held in Marion, with Dr. Daniels as chairman of the Committee on Arrangements.

Dr. Daniels is a member of the Presbyterian Church, and is identified with a number of fraternal orders. In 1901 he was married to Miss Anna Overman, of Sweetser, and they have one son, Harry, and one daughter, Mary.

In appreciation of Dr. Daniels' service the Association has done well to bestow its highest honor upon him by making him its presiding officer.

DIPHTHERIA IMMUNIZATION

Despite the fact that the Indiana State Board of Health, aided in a measure by a committee of our Indiana State Medical Association, and supported by editorials and editorial notes in The Journal, has been urging the adoption of toxin antitoxin as a diphtheria preventive among young children, the fact remains that very little has been accomplished throughout the state in reducing the prevalence of diphtheria, to say nothing of lowering the death rate from diphtheria. There is striking evidence of the need of some attention to this subject, for there really is no necessity for such a morbidity and mortality rate for diphtheria as exists in Indiana. Diphtheria can be wiped out through the intelligent use of toxin antitoxin, and the mortality from diphtheria can be negligible if antitoxin is used sufficiently early and in large enough doses. The State Board of Health through its educational campaign can do much toward improving the condition but help must come from the individual physician. While we are talking a whole lot about the oncoming of socialized or state medicine, and complaining about health nurses and members of health boards practicing medicine in competition with legitimate physicians, isn't it true that we are helping to bring about such a state of affairs by neglecting to do the very things that health officers want us to do even when we are paid for it, and which eventually the public will have to have done by health officers or others if we do not do it. In other words, we know what ought to be done in the prevention as well as treatment of disease, so why don't we do it before someone else does it for us?

HOSPITAL STANDARDIZATION

In this number of The Journal we publish a letter concerning hospital standardization and the sentiments expressed prompt us to offer some comment.

There can be no doubt that standardization of hospitals has brought about improved conditions, but the question arises, as pointed out by our correspondent, if standardization has not been too much by rule of thumb and without sufficient regard for the interest of the patient who in the last analysis is the one to be served. The physician into whose hands the patient places himself comes a strong second.

There has been much complaint concerning the rules laid down by the American College of Surgeons covering the manner in which hospitals shall be run in order to be approved, and this complaint has been voiced privately though sometimes openly by many very prominent and capable surgeons who are members of the College and are interested in everything that pertains to progress in the diagnosis and treatment of disease. In the first place there has been much criticism concern-

ing the manner in which approval of hospitals has been secured, for it is a well known fact that some approved hospitals lack a great deal of meeting the standards set by the American College of Surgeons, and they lack still more in following the rules that have been formulated for their guidance. Just how has that approval been secured? As intimated by our correspondent, and others, it may have been secured as a direct result of special influence or clever manipulation on the part of hospital administrations in "putting the best foot forward" when making application for approval. Is it not probable that inspectors for hospitals not always are thoroughly capable of judging as to the qualifications of a hospital? In one instance that has been brought to our attention it was reported that the inspector sent to pass upon the qualifications of a hospital was wined and dined from the time of his arrival until his departure, and it was a foregone conclusion that the hospital would be approved whether worthy of it or not, and as a matter of fact approval was granted, though there was much to show that the hospital never did and does not follow the rules laid down for approved hospitals.

Physical equipment is necessary in the conduct of a hospital, and there is a certain amount of it that is absolutely necessary for trustworthy work, but education, training and morale of the staff is of prime importance if good service is to be rendered. Attention to details is of importance, but it is a question if the interests of the patient have not been lost sight of entirely through the attempt on the part of some hospitals to carry out the superfluous and exacting details or requirements recommended by the American College of Surgeons. The very fact that exacting rules have been prescribed by outside dictators for the guidance of hospitals has led some hospitals to go a step further and adopt stringent rules of their own creation that are unnecessary, superfluous and burdensome, to say nothing of being of no special value to the patient who, in the final analysis, is the one whose interests should be considered.

Our correspondent has mentioned some features that are open to criticism, and others might be added. As an instance in point, a very prominent young physician was advised to have his tonsils removed, and he elected to go to a hospital for the operation, but a day prior to entering the hospital he had a complete blood examination, including Wassermann, leukocyte count, and coagulation test. He also had a chemical and microscopical urinalysis. However, the hospital insisted upon duplicating the procedure, as it was one of the rules, and the doctor was charged the regulation fee for the service. As a matter of fact the surgeon was responsible for the patient, and if derelict in duty he should have been disciplined, but our contention is that the hospital has no business to take from the surgeon the function that properly belongs to him. Even intelligent patients are beginning to complain concerning the exactions and unnecessary routine followed by some hospitals that seemingly are trying to find out how much extra work they can do for any patient who enters the hospital, with added expense, whether the attending physician or surgeon asks for it or not. In fact, much of the complaint concerning the high cost of sickness can be traced to the rapidly increasing cost of hospitalization, with all of the extras that are tacked on for superfluous service which oftentimes include expenses of an unnecessary special nurse, unnecessary laboratory tests and examinations, and the extra charges for dressings, sutures, etc. No just complaint can be offered concerning the attempt to improve the efficiency and quality of service of the hospital, for that feature is commendable and deserves encouragement. However, it seems to be a very patent fact that we are "straining at a gnat and swallowing a camel" in insisting upon much service or attention that is superfluous, and we are overlooking to a large extent the all important point that the patient and his physician should receive consideration when deciding upon the kind and amount of service. At the present time it would seem that a good portion of the medical profession is run by the hospitals instead of the hospitals being run by the medical profession. Certain it is that any medical man, no matter how well qualified or experienced he may be, is obliged to bow down in deference to hospital rulings and standardization whether the policies and rules suit him or not. Isn't it quite possible that in the near future there will be a revolt that will end in disaster insofar as standardization is concerned?

(A prominent surgeon, fellow of the American College concerning hospital standardization which are as follows.)

The primary aim of the hospital standardization movement was to give to hospital patients better service at no material increase of cost to the patient. Have these aims been met in a satisfactory measure up to the present time? The writer has no hesitancy in answering *"no"*.

Many hospitals are doing much unnecessary x-ray and other laboratory work for patients and charging it to them. Recently the writer saw the bill of a patient of his which charged, among other things, for a blood examination and urinalysis, $6.00; for dressings, $1.50; for medicine, $1.15, and for sutures, $.30. The blood and urinary examinations had been done the day before the patient entered the hospital. His wound, a clean appendix, was dressed once in the operating room, once at the end of the first week, and again at the end of the second when he was discharged. As to medicine he was given three one-fourth grain tablets of codeine. The sutures charged for were furnished by the writer. Item-

ized accounts like the above would require a corps of bookkeepers if they are to be kept correctly. To ask the nurses in training to keep these accounts is unfair. The nurses are in the hospital to be trained in caring for the sick and not to be trained as bookkeepers.

Emphasis on the importance of book and record making, scrubbing floors, and other non-essentials takes the time of the nurse away from more essential matters, and the result is that the standardized nurse is annoyingly, and in some cases harmfully, ignorant in matters essential. To illustrate, the writer recently during an operation asked for an ureteral catheter. Not one of the nursing force in the operating room, this included the head of the operating department, knew what an ureteral catheter was. In another hospital the writer wanted a trocar to empty a gall-bladder, and not a nurse present, and there were three or four, knew what a trocar was. In still another hospital, and of course none but standardized hospitals are referred to, a volsella was asked for, and not a nurse present knew what was wanted. Instances of this kind are of common occurence, and according to the observation of the writer and a number of his surgical friends they are growing more common.

In the groups of nurses referred to in the foregoing illustrations ignorance of the "rules" did not seem alarmingly prevalent for one of the nurses told the writer he should defer operating on an acute appendix until "they had time to make a blood count"; another that "no nurse should ever give any nourishment but water to any patient after an operation without a written order from the doctor"; another who had awakened a serious goitre case, who needed rest badly, at 4 o'clock in the morning to take her temperature replied, when I criticized her for lack of judgment—"why, Doctor, that is the rule, and I had to obey."

The increased clerical and similar duties put upon the nurse has made it necessary to hire specials for patients who as a matter of fact could, and in fact in pre-standardized days did, get perfectly satisfactory service from the floor nurses. Not only is the special nurse in many cases unnecessary, but in addition she entails a financial burden on the patient that is often very hard to bear. Another point worth mentioning in connection with the employment of special nurses is that the employment of one seems, in the light of experience, to shift the whole responsibility on to the shoulders of the "special". Ask the supervisor or floor nurse about a patient served by a "special" and the reply is, "I don't know, she has a special."

It is an open question that neither the medical and surgical service, nor the service in the managerial departments have been very materially improved under standardization. Within a year a superintendent complained to the writer that there were being made too many post mortems.

All too many incompetent individuals remain on the medical and surgical staffs and in many managerial and nursing departments of our hospitals. Rules may not supplant reason in hospital management without detriment. The cornerstone of every first class hospital is the staff. When you get away from that fact you are off the road that leads toward the ideal hospital. The paramount duty of those seeking to organize a hospital is the selection of a staff of physicians and surgeons.

I might go on, but to be too tiresome would defeat my object which is to start without unnecessary delay a movement which will result in the improvement in hospital service which the men who are responsible for the origin of hospital standardization had in mind when the movement was started, and which all well wishers of improved medical and surgical service always have had and always will have in mind. It is pertinent to remark here that the writer is a founder in the A. C. S.; that he has given of his time and money to the advancement of its ideals; that the men active in the movement have his highest esteem, confidence and admiration; that he thinks the college an organization of unexcelled potential power in the advancement of medicine; but that this power could be better exercised, especially in the direction of improved hospital service than it has been up to date. One should be charitable in his criticisms of the College when he considers the enormity of the thing. To the writer the task of bringing about the improvements necessary is a prodigious one but not an insurmountable one. The task must also be a continuous one if progress is to be continuous. The movement should originate in and be an integral part of the College, and at the head of the movement should be a physician of wide experience in both hospital and private practice and one who has the confidence and esteem of the medical profession. Moreover, he should be a man of pleasing personality, and with executive ability. Put such a man at the head, grant him the authority and the financial backing which the job warrants, and we soon will have a department of hospital service that will bring satisfactory results.

(A prominent internist was asked to express his views on hospital standardization and he has sent us the following.)

Hospital standardization has worked too much good to warrant any criticism of a categorical character. It probably is safe to say that every hospital subscribing to the standardization rules laid down by the American College of Surgeons has been benefitted thereby. On the other hand, these rules, like all others, must have their exceptions, and any inelastic interpretation of them inevitably must result in stupidity and error. For example, certain routine laboratory tests are made

upon every patient admitted, at the patient's expense, regardless of how little these tests may benefit him or even protect the hospital, merely because "that is the rule". It often happens that the new admittant has just been subjected to a thorough, perhaps a complete examination entailing every laboratory procedure that possibly could have a bearing upon his case. Repetition of these procedures at the patient's expense works a pecuniary hardship and is manifestly unfair. If it is for the purpose of protecting the hospital, transcription of the referring physician's or surgeon's record would serve that purpose eminently satisfactorily, and would save some of the financial burden that already is unduly great if not literally prohibitive for the man of moderate income.

Routine clinical pathological tests either should be made without additional charge to the patient, or should be made only "unless otherwise ordered." Under present conditions "lab" fees that are "extra" are about as unwelcome as a "cover charge" in a restaurant, and almost as unjustifiable.

Again, a hard and fast rule often prescribes that no one be permitted to enter the operating room unless wearing a cap and gown when, as sometimes happens, he might as well be wearing a mackintosh and carrying a harpoon. Nor must any surgical dressing be done except by hands encased in sterile gloves, when many of them equally justly might call for a Prince Albert and spats! The rules common to all, or at least most, hospitals are not the only ones that fail because of lack of elasticity. Rules, like authority, are dangerous forces because the "enforcement agents" are frequently lacking in judgment.

Visiting hours and visiting days must, of course, be limited if the hospital is to accomplish its necessary care of the sick and the equally necessary attendant housekeeping. But it never seems to occur to the management that such observance of "regular visiting hours" results in a pandemonium definitely harmful to patients that need rest, and that restriction of visitors would aid more in solving this problem than restriction of hours. As it is, Sunday in most hospitals is about as quiet as Armistice Day on Fifth Avenue, New York. Very recently a patient in a reasonably well-ordered hospital gave as an excuse for being tired that she had had *fifty-seven* visitors that day, and upon her physician's protest, the hospital denied all responsibility on the ground that "no limit had been placed upon the number of visitors." Carelessly he had forgotten to tell the nurse in charge not to let them hold band practice in her room!

"Routine charting" is another field in which improvement may well be desired, if not expected. Meticulous attention is given to accurate charting of the pulse and temperature of a convalescent fracture of the femur, and the respiration in a pneumonia case entirely scorned; the quantity of urinary output in a nephritic ignored; and the fact that a "toxic vomiting of pregnancy" has succeeded in retaining twenty-four ounces of liquid nourishment is treated as wholly irrelevant and immaterial.

Hospitals justify their existence in proportion as they serve the sick. Every other consideration must be subordinated to that paramount purpose. To do this, rules and regulations must be laid down and, in the main, adhered to, but so long as rules are not "made to be broken", they always should be permitted to "bend".

PROMOTING SELF-PRESCRIBING

No one knows better than the editors of the medical journals how self-prescribing is promoted indirectly through the influence of the medical profession. A drug or pharmaceutical specialty or some physical therapy apparatus is introduced to the medical profession, and in the beginning advertised exclusively in medical journals. Sometimes the statement is made that under no circumstances will sales be made direct to the public, and yet after success is assured through endorsement and use by physicians, the article that was advertised exclusively to physicians is finally advertised to the public. Aspirin, argyrol, mercurochrome, and a number of other preparations that originally were sold and advertised exclusively to physicians, finally have been advertised and sold to the public. Various forms of physical therapy, including ultraviolet, infra-red, and so-called sunlight lamps, were first advertised and sold to the medical profession. Now they are advertised and sold to the public. One firm goes so far as to say that it invariably recommends that people should not use these various ultraviolet or solar lamps except under the advice of a physician, and yet if that is the case why advertise them to the public? Most of the manufacturers of this kind of apparatus are now catering direct to the public, and it remains to be seen whether the public is going to be harmed or not, for ultraviolet lamps may prove to be dangerous playthings if placed in the hands of lay persons for such indiscriminate use as undoubtedly will be given them. It is perfectly natural that manufacturers should want to increase their profits, and many of them are not particular about the ethics involved in the increase of patronage. A few of them are not interested in any damage that may occur as a result of indiscriminate and unintelligent use of their products. In the final analysis the medical man is at fault, for he takes his patients into his confidence and does not hesitate to impart information that oftentimes is a dangerous thing for the patient. A little knowledge is a dangerous thing when it comes to using agents that potentially have within them the possibility of producing great harm, but it is this little

knowledge obtained from the medical profession that proves very valuable for the manufacturer who makes his direct appeal to the public and profits from the sale of his wares.

OUR ASSOCIATION'S ACTIVITIES

At the Gary session, to be held this month, the officers and committees of our Association will report their activities to the House of Delegates. Their formal reports are printed in this number of THE JOURNAL and we urge every member of the Association to read the reports with a view to knowing just what is going on and what has been done in the interests of the Association and what action has been taken concerning matters that pertain to medical practice.

Admitting that there always is room for improvement, we still believe that we have reason to be proud of what is being accomplished. The executive secretary's office has been active throughout the year, and at times the work has been so heavy that it was with difficulty that everything was accomplished that falls to the lot of that office. However, in Tom Hendricks we have an executive secretary who works faithfully and well all the time, and he constantly finds additional work to do that is of interest and value to the Association and its members. With it all Tom is genial as well as tactful and capable, so he merits the appreciation and friendship that has been given him by practically every member of the Association who has come in contact with him. He has rendered valuable service to each and every one of the committees, the officers, the secretaries of county medical societies, and THE JOURNAL.

The Council deserves credit for the faithfulness with which duty has been performed. If any one has an idea that the Council is a mere figurehead he should attend one of the Council meetings and note the seriousness with which the various problems and questions confronting the Association are considered. The Council is, as it always has been, a body of capable and conscientious men who are working for the best interests of the Association and the profession at large, and it has been eminently fair and impartial in all its recommendations and findings. It is a distinctly representative body, with a councilor from each district who has been selected by the confreres of the individual district. There never has been any politics in the Council and probably never will be if that body continues to be composed of high-minded and thoroughly respected and representative men from the various districts.

For the most part the committees have functioned well. The Executive Committee has met regularly and taken action upon many important questions. The recommendation that three members of this committe should be in Indianapolis or very close to Indianapolis is worth serious consideration, for there should be a quorum within easy reach. However, to avoid any undue criticism on the ground that the entire committee comes from one section, it would be well to have two members of the Executive Committee residing outside of Indianapolis, for definite action on any urgent matter always can be secured from the outside members, through correspondence or telephone, when necessary. In fact we are inclined to believe that any outside member of the Executive Committee willingly would go to some inconvenience, trouble and expense to attend any very important meeting of the Executive Committee if requested to do so. One of the most important functions of the Executive Committee is to care for the medical defense feature of the Association and this has been done in a commendable way throughout the past year. In fact, it would be just as well for members to know that the medical defense feature of the Indiana State Medical Association is the best managed and most successful of any enterprise of its kind promoted and carried out by medical associations. We not only care for members well in every instance where they are entitled to the Association's benefit, but the expense has been at a minimum throughout the entire sixteen years that the enterprise has been in force. As stated by the committee, the medical defense feature is provided at a cost of only seventy-five cents per member per year, whereas in some other states the sum has gone as high as ten dollars per member, and we might add that in one state the expense in one year rose to twenty-five dollars per member. Furthermore, this feature is functioning with absolute efficiency, and during the last sixteen years not a single physician who is a member in good standing of the Association, as required by the by-laws concerning medical defense, and whose case is a legitimate one, has failed to receive defense from the Association. During the sixteen years that the medical defense feature has been in operation, the receipts have been nearly $33,000, and the total expenditures about $15,000. There is, therefore, over $15,000 surplus in the treasury, a condition of which the Association should be proud. In connection with the committee's report we desire to call attention to malpractice cases arising from insanity inquests, and to quote the opinion of our attorney concerning testimony in insanity inquests which is as follows: "A physician does not have to testify before a justice of the peace unless he so desires, and no contempt proceeding could be filed against a physician who refuses to act as a witness in insanity inquests in a justice of the peace court."

The Committee on Medical Education and Hospitals has been active, though we think it should give more consideration to the question of hospital standardization rather than leave all the phases

of that mattter to outside interests. What already has been accomplished in the matter of passing upon hospitals that are desirable for interns is commendable. Of especial interest is the recognition of the fact that there is a demand for nursing of the simpler ills, and this should be met by a short period of training of young women who can afford to work for a weekly charge that will not be beyond the means of the great mass of people who have moderate incomes. There is a place for the highly trained and specialized nurse, but there certainly is room for a great army of "practical" nurses, if we may so call them.

As usual the Committee on Necrology has made a very careful and interesting report, and in connection with this report we desire to emphasize the importance of sending to THE JOURNAL obituary notices. At present we are forced to rely almost exclusively upon the newspaper clipping service, which oftentimes is inadequate if not inaccurate. We especially desire to enlist the co-operation of the county medical society secretaries in sending obituary notices of their members along with other news notes and personals.

The Committee on Industrial and Civic Relations is one of the valuable committees of the Association and its chairman has been of distinct service to the profession in the arbitration work necessary in the settlement of disputes concerning service in industrial cases. The Committee will be of greater service if more members of the Association will avail themselves of the service that is offered.

Too much credit cannot be given the Committee on Publicity, which is composed of some of the most representative men in the profession and men of outstanding ability. When we consider that this committee has a weekly release to the lay publications of Indiana and has not failed in a single instance to have a most creditable article on some phase of individual and community health for publication in the lay press, it can be well understood that the Committee has done an enormous amount of work for which due credit should be given. Furthermore, the fact that those articles have been accepted by a very large proportion of the newspapers of Indiana and published regularly, is indication that the committee's work has been exceedingly well done, and with fine regard for the appropriateness of the material presented. The work done by this committee ought to be a very potent factor in educating the public concerning disease recognition and prevention. Each and every one of the releases is written with the idea of having it an educational feature, on a scientific basis and free from personalities or criticisms of creeds or methods of treatment. The name of no member of the Committee or any physician is attached to the articles.

One of the new committees is that on Secretaries' Conference, and we believe that in the future this committee is going to accomplish a great deal of good in the interest of the individual county medical societies of the state. We often have said that a secretary can make or break a society, and sometimes a county medical society secretary needs some stimulation outside of his own community. If so, he should get that stimulation by contact with the other secretaries of the state. We earnestly urge every county medical society secretary to attend the secretaries' conference for the purpose of getting enthusiasm and new ideas that will help him in his work of building up his own county medical society.

The Diphtheria Committee has not accomplished all that should have been accomplished, but failure can be charged to the individual physicians of the state who have not given the matter serious consideratoin. Diphtheria can be wiped out just as smallpox has been wiped out, but to accomplish this end there must be an active co-operation on the part of every physician of the state who should be vitally interested in urging the toxin-antitoxin preventive treatment for pre-school children of his community. We hope the Diphtheria Committee will be continued and that, in co-operation with the State Board of Health, the matter of diphtheria prevention be brought directly to the attention of every individual physician of the state through a personal communication urging him to get behind the movement.

THE JOURNAL speaks for itself as a report. Constructive criticism is solicited and at all times we welcome contributions of whatsoever nature that seem to be of interest to the profession at large. The editor of THE JOURNAL has attempted to uphold and maintain the best traditions of the medical profession, and to champion anything that stands for medical progress and the high ideals of ethics and propriety. Even the advertising pages have been subjected to critical analysis with a view to deleting any advertising that can be considered objectionable from the ethical point of view. This has meant the loss of much income that could be derived from advertising that is only slightly "off-color" but we prefer a high standard of quality rather than added income.

The finances of the Association are in excellent shape. Probably no state medical society can make a better showing considering the relatively small amount charged as dues, and the accomplishments through the varied activities which have been managed so well, so economically, and with such splendid results. It is hoped that we will continue to have a surplus, and that there will be no foolish appropriations simply because there is a surplus.

If we were to offer any specific recommendations to the Association, it would be that some effort should be put forth to bring about a closer affiliation between the Association and the Board

of Health, and the Board of Medical Registration and Examination. Many outside activities need the active counsel and support of our Association in order to accomplish the most good. For instance, if the Association took an interest in appointments to the State Board of Health, and worked to divorce the appointment from rank political favor, and insisted upon having appointments based upon ability and fitness for the position, we would not witness the spectacle of having a Board of Health wrangling with its members concerning the inauguration and carrying out of policies that are of vital interest to the people. We also would have a Board composed of representative and well-trained physicians, all of whom would take pride in being identified with reputable medical societies instead of being contented to be ranked with the quacks and pretenders.

Another matter which should receive attention at the hands of the Association is that of furnishing postgraduate instruction to the individual physician. Some effort along this line has been carried out in Evansville and Terre Haute with creditable success, but the work should be more widespread throughout the state. The Michigan State Medical Society is bringing postgraduate clinics to its members in various sections of Michigan, and what Michigan is accomplishing Indiana can.

Finally we have the utmost faith in the success of the Association in furthering the best interests of progressive medicine, as well as the interests of the individual practitioners of the state, but we desire to urge the profession as a whole, as well as the individual members of the profession, to work as a unit. The criticism we would offer is that the individual physicians are too apt to be looking out for themselves and manifesting a spirit of "Let George do it" when they themselves should put their shoulders to the wheel if the most is to be accomplished. Nothing worth while is accomplished without work, but all work must have a purpose, and all workers must exert a spirit of co-operation and helpfulness as well as friendliness toward each other.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

The time—Wednesday, Thursday and Friday, September 26, 27 and 28.

The place—Gary, Indiana.

The event—The annual session of the Indiana State Medical Association.

Do not neglect to take your membership card with you to Gary as it will be required when registering.

This number contains the complete and official program of the Gary session. Read it carefully and go to Gary prepared to take part in the discussions.

Again we are publishing a list of the presidents of the Indiana State Medical Association from the founding of the Association up to and including the present date.

Several Indiana physicians who have attended the Mayo Clinic or been associated with that clinic in any way whatsoever received publicity in the *Muncie Star* of July 15th. We suppose that this is legitimate advertising.

If anyone thinks that a trip through the steel mills at Gary will not prove interesting he has another think coming. Don't fail to take in the trip. Special cars will be provided and it is the only way the trip may be taken.

Those who are presiding at the various meetings of the Gary session are reminded that every meeting must be called on time and those who take part in the program should be informed that they will be limited to the time set for their use.

As we said last year it is a good plan to let your patients know that you are interested in medical progress sufficiently to justify you in being away from home to attend the State Association session. It is quite appropriate to have such an announcement tacked on your door.

The naturopaths had a meeting at Indianapolis in July. The newspapers spoke of it as a "parley." What those chaps had to talk about is not mentioned, as a clipping we received carried one announcement only, and that was that a certain minister would pronounce the benediction. A good ending.

All of the meetings of the Gary session will be general meetings. This is in response to a desire on the part of many members to do away temporarily with the section programs. It is not expected that a precedent has been set but that next year the Association will go back to the usual plan of having section meetings.

The New York State Journal of Medicine is getting a lot of protests from reputable members of the New York State Medical Society con-

cerning the rotten advertising carried. However, the protests seem to fall upon deaf ears, for commercialism rules at present, but if we are not mistaken a few medical men in New York are riding for a fall!

TREATING diabetics under thirty pounds of air pressure is the freakish notion of a Kansas City doctor that is to be carried into effect through the erection of a steel cylinder in which diabetics are to live for a week at a time. The surprising feature about the proposition is that a man was found who was willing to give one million dollars toward the enterprise.

MEMBERS of the House of Delegates are reminded that this year the first meeting will be later than it was last year. It is to be held in the basement of the Hotel Gary at 6:30 p. m. on Wednesday, September 26. The final meeting will be a breakfast meeting on Friday morning, September 28 at 7 a. m. It also will be held in the basement of the Hotel Gary.

DESPITE the fact that this year's session of the Indiana State Medical Association will be held in Gary, it should be understood that Lake County, which contains several other cities and towns outside of Gary, is actively interested in entertaining the Association. If it were not for establishing a bad precedent we might with propriety call this year's session the Lake County session.

GARY should bring out a large attendance, for it is easily reached from all sections, even though in the extreme northwestern part of the state. An abundance of railroads, traction lines, and good paved roads lead to Gary. If you are going by automobile, consult your automobile association and get a map that will indicate the most direct route as well as any detours that are to be encountered.

FROM *Time* we learn that in Rumania, where tobacco is a state monopoly, punishment is meted out to the non-smoker who brazenly rides in a smoking car with intent to sniff tobacco fumes and thus enjoy the tobacco effect without expense and without twinge of conscience. Interesting, if true, but we can't imagine that any person would enjoy getting the effects of tobacco in such a second-handed way.

COMMENTING upon a complaint that some medical and surgical fees are too high, the *Evansville Indiana Courier,* for July 24, says that "One way to lower doctor's fees would be for patients to pay the fees promptly and ungrudgingly as they pay regular business obligations. Doctors might afford to charge less if they were sure of getting it within a reasonable time." To which we say, "Amen."

WHILE you are thinking about how you are going to vote in the November elections, don't forget that the man you are sending to Congress will have a voice in helping or defeating much legislation pertaining to the practice of medicine, some of its beneficial and some of it harmful. Therefore, try to have your ballot count for the men whom you know are in favor of legislation helpful to the medical profession.

THE Indiana State Board of Health is warning housewives against the use of chemical preservatives in fruit canning, on the ground that antiseptics in connection with canning are totally unnecessary and serve the purpose only of the ignorant and those practicing unsanitary methods,

The Following Prominent Physicians From Out of the State Are On the Program for the Gary Session:

HENRY FREDERIC HELMHOLZ, Professor of Pediatrics, University of Minnesota Medical School, Rochester.

PALMER FINDLEY, M.D., President of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Omaha, Nebraska.

M. EDWARD FRANCIS, M.D., United States Public Health Service. Awarded 1928 Gold Medal for Research by the A. M. A.

ALBERT KEIDEL, M.D., Associate Professor of Clinical Medicine, Johns Hopkins University School of Medicine, Baltimore.

WILLIAM ALLEN PUSEY, M.D., Emeritus Professor of Dermatology, University of Illinois College of Medicine, Chicago. Past President American Medical Association.

JOSEPH C. BECK, M.D., Associate Professor, University of Illinois College of Medicine, Chicago.

SIDNEY STRAUSS, M.D., Associate Professor of Medicine, University of Illinois College of Medicine, Chicago.

HARRY SEARLES GRADLE, M.D., Chicago.

W. H. ORDWAY, M.D., Assistant Medical Director for the Metropolitan Life Insurance Company, Mount McGregor, New York.

and for the further reason that preservatives when added to food have been definitely demonstrated as injurious to health. If the canning is done as it should be done there is no need for preservatives.

In the August number of The Journal an editorial comment on the advantage of using brominized oil in bronchography in tuberculous patients, as presented before the clinical congress of the American College of Surgeons at the Detroit session, should be corrected so that credit is given Samuel Iglauer, M.D., of Cincinnati, and Hugh A. Kuhn, M.D., of Hammond, Indiana. The preparation used was bromopin, the endobronchial injections of which produce no irritating effects on the tissues.

The committee on arrangements has asked us to emphasize the following: Hotel reservations may be secured through the local committee, of which H. M. English is chairman, 607 Broadway, Gary. Those who desire to enter the golf tournament at the Gary Country Club should get in touch with T. B. Templin, M.D., 579 Broadway, Gary. Those who expect to attend the service men's luncheon are asked to communicate with Dr. Simon J. Young, 583 Broadway, Gary. Those interested in the class reunion luncheons are requested to write R. N. Bills, M.D., 583 Broadway, Gary, who has them in charge.

The members of the Indiana State Medical Association should take advantage of our Committee on Civic and Industrial Relations in controversies over the settlement of bills for professional services rendered in industrial cases. The committee acts as an arbitration committee and has been the means of establishing better relationship between physicians and employers of labor and their representatives, the insurance carriers. If you are having trouble in securing just and adequate settlement of your claims for services in industrial work, place the facts before the committee on Industrial and Civic Relations of which Dr. Frank R. Crockett, of Lafayette, is chairman.

The people must be educated as to the value of health examinations. Physicians should be willing to give of their time and talents in acquainting parents with their responsibility for their children and the importance of periodic examinations in order to detect defects which not only tend to increase with the development of the child, but may be corrected if given appropriate attention. We never are going to get anywhere if we take the stand that pre-school examinations must be given to every community gratuitously now and forever afterward. It should require no far-seeing individual to see the vicious results that may follow this sort of pauperizing service.

We have received a complaint from one of the prominent members of the Indiana State Medical Association concerning the fact that the president of the Indiana State Board of Health is not a member of any reputable medical society, and in fact his offices are connected with those of a rather notorious quack who advertises and does everything else that an ethical physician will not do. Politics certainly makes strange bed-fellows, and our sympathy goes out to the secretary of the State Board of Health whose efforts to create and maintain a high standard of service must in a measure be hampered by the work and influence of a member who is discredited by the regular medical profession and who evidently owes his appointment to politics.

In this number we publish an article by the epidemiologist of the State Board of Health concerning undulant fever, a disease communicated through milk supplies and at present quite prevalent in Indiana. The secretary of the Board also has an article in the *Journal of the A. M. A.*, of August 25, under the title, "Control of Public Milk Supplies" in which he emphasizes the importance of health officials giving attention to infectious abortion in cattle which has been proved to be the cause of undulant fever in man. It is his opinion that the disease will give us more trouble if we do not begin to deal with it now. Pasteurization of milk is considered a real necessity, and all health officers are asked to pay special attention to the milk supplies of their various communities.

In carrying insurance it would be well for physicians to know that if they hold policies in companies that are not licensed to do business in Indiana it would be difficult to force such companies to meet obligations inasmuch as they cannot be sued in the courts of Indiana. Probably not one person in ten has determined whether the insurance company in which he holds a policy is legalized to do business in this state or not, but the obligation exists just the same if the full amount of protection is to be obtained. No doubt there are some insurance companies that would live up to contracts whether they are licensed to do business in Indiana or not, but, on the other hand, there is a possibility that trouble might occur in the event of controversy and it is well to be on the safe side.

The Fort Wayne *News-Sentinel* for August 17 says that one of its employees who was blind in the left eye from childhood had his sight restored suddenly and miraculously by a bug which flew into and bit the blind eye. It is reported that upon removal of the bug the blindness disappeared, and a specialist (?) who was consulted the following morning for an explanation "gave it as his opinion that the bug had bitten through a

delicate scum on the eye, permitting movement again of the iris which hitherto had been immovable." Such is the kind of sensational nonsense that occasionally is published by newspapers, and believed by credulous readers. Perhaps a few blind people now will be spending the rest of their lives trying to find a bug to bite them in the eyes to restore vision. Vain hope!

A MEDICAL friend writes us that on one of the piers in New York City in an emergency hospital station he saw a nurse amputating a crushed finger, and learned that it was a common thing for the nurses to do emergency surgery. The surgery was rotten, as might be expected, but it is a part and parcel of a certain kind of social service which a lot of people are squawking for and seem determined to put into operation. Well, history may repeat itself, so perhaps the barbers will begin doing surgery again. In a few years more there will be no need for well-trained surgeons, for social service stations, health nurses, chiropractors, barbers and carpenters who do not fear to spill blood will be on hand to render any services that may be required in case of injury. Who is practicing medicine? Why, everybody is doing it! God have mercy upon the man who thinks it necessary to be trained for the work in order to get "business."

SINCE Indiana is licensing drugless healers our newspapers are profiting by the advertising those pretenders employ to attract attention. Some of the advertising of the drugless healers reminds us of the old time quack doctor advertising which not only asserted that the advertiser was "a specialist in all diseases," and that there was no ailment of the human body that he could not cure. Of course, the drugless healers will find dupes, and it is unfortunate that the ignorant and the poor, the ones most apt to take up with drugless healing and medical fakery of every sort, have not been protected properly by law. We may be very dense, but at this particular time we are unable to discover any special reason why we should have any medical laws governing the practice of medicine, for as far as we can see most any one can practice medicine whether licensed or not, and even if licensed the legal recognition does not mean anything, as in the case of the drugless cults.

NOT many individuals, and especially those not drawing fat salaries, would be interested in welfare work of any kind if they did not get a good deal of advertising out of it. If you don't believe this ask some of your newspaper friends and see what they say about the matter. Most of the uplifters have a craving to be in the limelight, and whenever they are associated with any welfare work they go to any trouble to see that newspapers and magazines give a comprehensive report of their activities, and not at all infrequently the copy for publication is supplied, always in eulogistic terms of the one who is doing the work, and oftentimes accompanied by photographs of the erstwhile self-sacrificing worker who feels amply repaid for services rendered if the publicity is pronounced. The welfare worker who is doing conscientious and really valuable work and keeps out of the limelight, and avoids newspaper and magazine publicity, is almost as rare as a hen's tooth.

THE abuse of medical charity is well illustrated by the case reported by the *New York Sun* of August 8th, in which an old man, afterwards discovered to be rich, applied for treatment at the out-patient clinic of a hospital, accepted and received six months' gratuitous treatment, and finally entered the hospital for a major operation for which he had agreed to pay the minimum charge for room and nursing. He was accepted as a charity patient and a major operation performed. He died thirty days later, when it was learned that he left a fortune of more than $400,000. The case is analagous to many more of a similar character showing the extent of misplaced charity and the deception practiced by many people in soliciting and accepting valuable hospital and surgical services as a gratuity when amply able to pay for the same. It is very evident that some more stringent system should be adopted in most clinics and hospitals for determining the financial status of those who apply for services.

WE wish it distinctly understood that we are not opposed to child welfare work when it is conducted along proper lines. What we object to is the free clinics for all who come, with the bestowal of valuable medical advice, even to the point of prescribing for the patient, as a pure gratuity and with the unavoidable result of stimulating pauperism and dependency to say nothing of loss of self-respect on the part of a class of people who should have far different encouragement. We do not doubt that boards of health, child welfare associations, parent-teacher associations and other uplift organizations sincerely believe that they are performing a valuable service to society when they aid in the preservation or promotion of health through free clinics, but sometimes a lot of harm is done by misguided enthusiasts who bestow misplaced charity. We ought to bend every effort to make people self-sustaining and independent and desirable citizens of our country, and we can't do this if we are going to put into practice any paternalistic or socialistic ideas.

IT would be interesting to know the exact number of physicians in Indiana who have given any of their patients anti-typhoid inoculation. In

reality we are under the impression that this subject has not received the consideration that it deserves. We know that health officers have been extremely careful in looking after the food and water supplies of our cities and towns, but what has the individual physician done toward protecting the vacationist who goes camping or to the out-of-the-way places and runs the risk of drinking or eating contaminated water or food? It is hoped that the timely article by our Publicity Bureau entitled "Vacations and Typhoid Fever" was published in a large proportion of the newspapers of Indiana and that the article was read by a majority of the vacationists of the state. Aside from the usual recommendations concerning boiling of all suspicious water, and boiling or pasteurizing of suspicious milk, the last recommendation was that a wise provision would be to have the family physician give a series of anti-typhoid inoculations.

IN the August issue of THE JOURNAL we extolled certified milk, and we have no apologies to make for the opinion expressed. However, we realize that the difficulties are very great in securing certified milk that comes up to standard and for the reason that the human equation must be taken into consideration and carelessness may defeat the purposes. However, certified milk that does meet the requirements is especially desirable for the use of physicians in the care and treatment of sick people and babies, to say nothing of being the best milk for general consumption. On the other hand, we agree, in consideration of the very great difficulties in securing certified milk that measures up to standard, that our health officers can do nothing better than advocate the pasteurization of all milk especially in the face of the presence of communicable diseases that can be traced to milk. At the present time we are threatened with serious results from undulant fever which exists in Indiana, and for that reason pasteurization of all milk is justifiable as a protective measure.

THE Indiana State Board of Health is asking the co-operation of the physicians in a campaign of immunization to stamp out diphtheria. For several years we have been talking about this matter but little has been done. In fact, the individual physician has given the project little support, and it is time for action. Several cities in the United States and Canada practically have wiped out diphtheria through immunization, and while they have been doing that we have been losing 255 children a year (1927) and the State Board of Health declares that such a mortality rate is a disgrace, and we should get rid of it by an intensive campaign to stamp out diphtheria within the confines of the state. It can be done by immunization, but the work must have the support of the medical profession individually and collectively as well as Parent-Teachers' organizations and school physicians. If every individual physician in the state will recommend immunization for the pre-school children of his patrons we will go a long ways toward assisting in this work of eradicating diphtheria from the state.

THE *New York State Journal of Medicine* does not print the reports of the Council on Pharmacy and Chemistry of the American Medical Association, and probably for the very good reason that the reports would reflect on some of the advertisers in that journal. It would seem that if the *New York State Journal of Medicine* wanted to be in the forefront of modern medicine it would be willing to give its readers the Council's latest utterances which are obtained after much research and at much expense, by representative physicians from all sections of the United States, including some from New York. The truth of the matter is the *New York State Journal of Medicine* is not run entirely in the interest of scientific medicine or the highest standards of ethics and propriety or it not only would back up the Council on Pharmacy and Chemistry of the American Medical Association, but would refuse to accept some of the objectionable advertising that now disgraces its pages. For shame, that the official organ of such a large and influential society as that in New York should be guilty of rank commercialism!

WITHIN the last few weeks we have received three pamphlets from three disassociated physicians in various parts of the country, each covering an alleged cancer cure and the promoter of which claims respectability through membership in a local medical society. In each instance the cure consists in certain local applications and the internal administration of drugs reported to inhibit the growth of cancer tissue or as one physician says, "destroy the cancer germ." Whether these men are sincere in their belief or have the slightest proof to offer in support of their contention, or are actuated by desire for pecuniary gain, is hard to understand. A charitable interpretation justifies us in thinking that these physicians are sincere but ignorant and are led astray by results based upon false premises. It is also a little hard to understand how these men can continue to maintain membership in reputable medical societies, and they certainly seem to have maintained such membership if the American Medical Association directory can be depended upon. Evidently some of our medical societies ought to have a housecleaning.

THE *Indianapolis News* of July 28 says that a woman representing herself to be a Hindu has been arrested on a charge of practicing medicine without a permit, and the complaint is based upon

investigation by a social service worker who called on the woman and complained of several ailments. Seven bottles of the Hindu woman's "tea" selling for $14 were prescribed, but were obtained for forty cents. Her manager, a white man, has arranged to have an attorney defend her. We shall not be surprised if the woman is acquitted. Old Lady Piatt, a "string doctor" in Fort Wayne, who prescribes medicine in connection with various incantations, and numbers her patients by the hundred, has been able to defeat justice and still practices. If a well-trained physician, graduated from an A-1 medical school, begins to practice medicine in Indiana without being duly licensed, it is a foregone conclusion that he will be prosecuted at once and convicted, but the rankest kind of a quack and medical imposter can escape severe punishment in Indiana, as ample evidence shows. Is it public sentiment, or is it the lameness of our medical law? Or both?

A FEW months ago a prominent dietician announced that raw sauerkraut and especially sauerkraut juice is a wonderful tonic and alterative. Almost immediately the menu cards of the dining cars on our leading railroads and our "swell" hotels in all the large cities added sauerkraut juice to the bill-of-fare. Now comes another announcement to the effect that the juice from raw tomatoes is a good team-mate of sauerkraut juice. So falling in line are the dining cars and our leading hotels with tomato juice on the bill-of-fare. Thus on one menu card we noted that sauerkraut juice is listed at forty cents, and below it is tomato juice listed at the same price. Sauerkraut juice may have had its origin in Germany, where for a long time it has been very popular, but tomato juice drinking is distinctly an American innovation, though it is said that already it has spread to France and Italy. If you will pin your faith to tomatoes, be sure to have ripe tomatoes, without scalding, without other seasoning than salt, and don't omit to consume the juice. If whole tomatoes are used they should be skinned without the use of hot water, and consumed raw.

A reverberation from the children's clinic at Winona conducted by the State Board of Health, is to the effect that the work does not reach the class of patients for which it should be conducted. About two hundred children were examined, many of whom were from outside of the county and some from outside of the state. The examinations were made rapidly, and even some of the lay individuals who witnessed the examinations concluded that the work was very superficially done and not by persons who have been trained in the hard school of practice. The actual expense to the state was about $660, though there were many other incidental expenses in connection therewith. A member of the Kosciusko County Medical Society who has made some investigation concerning the Winona clinics states that in his opinion the work, insofar as the clinics were concerned, was practically without value and perhaps in some instances did harm as the result of the general feeling of many lay persons that the examination feature was very superficially and imperfectly done. The State Board of Health probably would accomplish more if it confined itself to lectures and demonstrations and cut out the clinics.

THE State Board of Health is putting on an intensive diphtheria immunization campaign in the city of Evansville as a demonstration. An effort will be made to work through the Parent-Teacher and other organizations in the city with a view to making a personal canvass of the entire city in the hope of getting as large a percentage as possible of children under ten years of age immunized. A special effort will be made to immunize children under five years of age. This campaign will be unique in that no special effort will be made to immunize children over ten years of age. They will be welcome if they desire it and their immunization is strongly advised, but from a public health standpoint children over ten years of age are relatively unimportant insofar as diphtheria is concerned, being relatively nonsusceptible. The Board feels that the pre-school child holds the key position, and in this campaign every effort will be made to have them protected. Protection of at least five thousand pre-school and five thousand children from five to ten years of age will be necessary to reduce the diphtheria rate of Evansville to zero or thereabouts.—*Bulletin Indiana State Board of Health.*

INDIANA physicians are receiving circular letters from the "Pickard Curative Institute," of Indianapolis, inviting them to attend a ten-day course in electrotherapy to be given by Dr. H. C. Bennett, of Lima, Ohio. The fee for the course is twenty-five dollars. You may think that this is advertising the course, but we are giving particulars so that you can shun the whole proposition. The Pickard Curative Institute is a quackish concern run by a licensed physician who, according to the American Medical Association medical directory, has no connection with a reputable medical society. The so-called famous (?) electrotherapist, Dr. H. C. Bennett, has quackish tendencies, as might be expected when he identifies himself with an institution like the "Pickard Curative Institute." He has no connection with reputable medical societies according to the American Medical Association medical directory. If any of our readers desire instruction concerning electrotherapy we suggest that they get it from

other sources, for there are reputable and well-trained medical men who are capable of giving such instruction, and who are not identified with quack doctors or quack institutions, nor could they be induced to engage in any practices of a questionable nature.

Several months ago we commented on the fact that the widely advertised denicotinized tobacco probably was not denicotinized to any great extent, and even if so that smokers would find little joy or comfort in indulging in a camouflaged product. Recently the chemist of the Connecticut agriculture experiment station has investigated the whole subject and issued a bulletin in which it is stated that the so-called denicotinized tobacco products are, broadly speaking, apparently denicotinized only in a Pickwickian sense. The promoters of denicotinized tobacco advertise "practically free from nicotine", whereas experiments show that the much-vaunted denicotinized tobacco is about as strong in nicotine as many of the regularly sold tobaccos on the market, all of which vary in nicotine content. As the *Journal of the A. M. A.* of August 25th says, "It is quite obvious that persons who purchase alleged denicotinized cigarettes are getting no such product as they are paying for. In fact, it would patently be better to buy some of the standard unprocessed cigarettes, having a low nicotine content, than to purchase some of the so-called denicotinized products. Not only would the purchaser get less nicotine in the same number of cigarettes, but he would not be lulled into a sense of false security and consume a larger number of cigarettes in the belief that the product smoked was largely or entirely free from nicotine."

We have received a questionnaire and prepaid reply envelope from the Medical Research Bureau of New York City in which inquiry is made concerning the use of sedatives and the names of sedatives preferred. We know nothing about the Medical Research Bureau, and are inclined to believe that no reputable medical men are connected with it or otherwise their names would be given in connection with the questionnaire. Our suspicions are aroused when the question is asked as to which of several sedatives are prescribed, and in the list mentioned are two or three proprietary remedies sold under quackish and extravagant advertising, and, of course, they have not received the approval of the Council on Pharmacy and Chemistry of the American Medical Association. Some Council-endorsed products are included among the objectionable proprietaries, probably in order to allay suspicion as to the object of the questionnaire. At all events we are not inclined to fall into such a trap as seemingly has been set for us, and we believe that all reputable physicians will be safe if they refuse to be a party to a questionnaire that may be twisted into endorsement of some objectionable proprietary. The unsuspecting physician too often is made the prey of the advertising proprietary medicine manufacturer, and it is just as well to follow the urge to refuse endorsement to enterprises of questionable character and patently for advertising purposes.

California knows how necessary it is to have an exclusion act. The Californians have been stimulated into race consciousness through the slogan of the Japanese which translated is, "A baby a year will make the whites disappear." And the Japanese birth-rate on the Pacific Coast, each Jap youngster born with full American citizenship, clearly showed that without exclusion it would not be long until the Anglo-Saxons would be displaced by Orientals. The immigration study commission, with offices in California, is now agitating the question of excluding or limiting the number of Mexicans who can enter this country, and the same argument is offered that has been effective in securing the exclusion of the Japanese and Chinese. The commission says that "most American parents are kept busy feeding and properly educating two or three children, whereas a Mexican thinks nothing of seven. It is estimated that we already have five times as many Mexicans here as we had negro slaves in 1776. The latter have multiplied to some ten million. Can America shoulder another colored burden five times as heavy?" We are quite in sympathy with all of the arguments that are put forth concerning the restriction of undesirable immigration, and we believe that the members of the medical profession are in position to appreciate the dangers that threaten America unless something is done to preserve our civilization against inroads of a deteriorating factor.

The Medical Journal and Record of New York City has started another questionnaire, and this time with a view to obtaining the opinion of medical men concerning the subject of alcohol and prohibition from the scientific point of view. The questions propounded are all of such nature that any unbiased observer would answer them in such a way that it would be considered an indictment against prohibition as at present carried out in this country. However, the time is wasted, for as one politician so aptly has said, "Our legislators and congressmen do not vote as they drink." In fact, we may add that they do not vote according to their own convictions. Nothing will be gained by furnishing evidence to the effect that in pre-prohibition days no one ever saw such widespread consumption of alcoholic beverages in the younger generation as we see today, and our courts and jails never have furnished so much evidence of alcoholic indulgence. The questionnaire furnishing such opinion will not serve any

useful purpose. If it shows preponderating evidence in favor of prohibition then it will be considered quite worthy of acceptance, but if it preponderatingly shows that from a scientific point of view prohibition has been a failure, then the fanatics will say that it is false, misleading, and unworthy of acceptance in any particular. In other words, the prohibition question is going to be settled one way in this country, whether right or wrong, for the rabid fanatics hold the whip hand. Whether the people will ever live up to the law or not is questionable.

THERE has been a good deal of friction and exhibition of personal peeves in the Board of Health during a period of two or three years. Both the medical profession and the public generally should realize that this has been a handicap to the Board in maintaining efficiency and integrity, for we probably are safe in saying that it is the vicious attempt to inject partisan politics into the State Board of Health which has caused all the trouble. Why, for instance, should any man be appointed as a member of the State Board of Health who has not the confidence and sanction of the regular medical profession, and who has not the reputation of having sufficient ability to fill the position to which he is appointed? Or why, for instance, should a man be appointed a member of the Board as a direct result of partisan politics and later be made president of the Board, and yet that same man hold himself aloof from reputable medical societies and hobnob with advertising quacks? It is time that appointments on all of our Boards upon which medical men are expected to serve shall be from a list of medical men of known ability and unquestioned professional standing, not only in the communities in which they live but in reputable medical societies. We hold no brief for Secretary King, who apparently has felt himself independent of the medical profession, and whose ability and integrity is unquestioned, but he certainly has had much to contend with in making his Board functionate in a satisfactory manner considering some of the narrow-minded and partisan actions of the other members of the Board serving with him. In the first place the State Board of Health should consist of men of ability and professional standing and, in the second place, the governor ought to say to the members of the Board that they must work in peace and harmony and to the best interests of the people of the state or get out of office.

THE legislative committee of a medical society in the State of Florida says, "It is possible now that the next State Board of Health will be under the control of osteopaths. The situation created by the new laws makes it more difficult for well-trained physicians to secure the right to practice and makes it easier for osteopaths, chiropractors and other cults to practice. The committee believes that this legislation was allowed to become a law because the medical profession failed to inform the public of its dangers." That shows what apathy of the medical profession will do. Kentucky recently has given in to the chiropractors, and Indiana, to our disgrace, now registers the drugless healers of almost every description. Some states are talking about the basic science law, and arranging to permit lay persons to give the examinations. What a fine mess we are getting into as a result of our apathy and indifference to the vital need of knowledge on the part of the public as to the dangers of permitting illy-trained and incompetent persons to practice the healing art. Furthermore, isn't it quite possible that with all of the pseudo-medical cults recogized by law, there will come a time when it will be extremely difficult for the well-trained physician to become licensed for the practice of medicine. The sum and substance of the whole proposition is that we are drifting rapidly to the place where it is just as well to have no medical law of any kind whatsoever. Certainly the people have little or no protection at the present time and fall an easy prey to the pretenders and quacks. There is just one reason, and one reason only, for this state of affairs, and that is the failure on the part of the regular medical profession to inaugurate and continue a campaign of education in favor of requirements for the practice of medicine that are consistent and in keeping with the safety of the public. Much is being said in the lay press at the present time concerning the high cost of sickness, but when you analyze the question you find that much of the superfluous cost arises directly through the misspent money paid to drugless healers and other pretenders. While we are talking on this subject of expense of sickness we must not overlook the fact that the regular medical profession is doing 99 per cent of the charity medical work. You do not find the drugless healers and the cultists of various shades and colors engaging in any charity work. Almost as a regular thing they get their money for what they do or they don't give the service.

DEATHS

WILLIAM J. REAVIS, M.D., of Evansville, died July 22, aged seventy-five years. Dr. Reavis graduated from the Medical College of Ohio, Cincinnati, in 1886.

THOMAS R. RUBUSH, M.D., of London, Indiana, died in Indianapolis August 13, aged seventy-four years. Dr. Rubush graduated from the Indiana Medical College, School of Medicine of Purdue University, in 1879.

James H. Black, M.D., of Lebanon, died July 26, aged fifty-seven years. He graduated from the Indiana Medical College, Purdue University, in 1906. He was a member of the Boone County Medical Society, the Indiana State Medical Association and the American Medical Association.

George H. Brodbeck, M.D., of Roann, died August 11, age seventy years. Dr. Brodbeck graduated from the Medical College of Indiana, Indianapolis, in 1882. He was a member of the Wabash County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

Harley W. Taylor, M.D., of Rochester, died August 17, following an illness of several months. Dr. Taylor was fifty-one years of age. He was a graduate of the Medical College of Indiana, Indianapolis, in 1905, and was a member of the Fulton County Medical Society, the Indiana State Medical Association and the American Medical Association.

Dewitt R. Good, M.D., of New Point, died August 15, aged fifty-seven years. Dr. Good served overseas several months with the medical corps during the last war. He graduated from the Chicago Homeopathic Medical College in 1896, and was a member of the Decatur County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

Charles J. Kirshman, M.D., of Muncie, was killed in an automobile wreck near Wabasha, Minnesota, August 12. Dr. Kirshman was thirty-six years of age. He graduated from the Indiana University School of Medicine, Bloomington and Indianapolis, in 1919. He was a member of the Muncie Academy of Medicine, the Indiana State Medical Association and a Fellow of the American Medical Association.

James Anderson Work, Sr., M.D., of Elkhart, died July 20, at Ann Arbor Michigan. Dr. Work was seventy-three years of age. He graduated from the University of Michigan Medical School at Ann Arbor, in 1870. He had retired from the active practice of medicine, but had maintained membership in the Elkhart County Medical Society, the Indiana State Medical Association and the American Medical Association.

Frank A. Priest, M.D., of Marion, died at Milwaukee where he was attending a convention, August 17. Dr. Priest was fifty-four years of age. He graduated from the General Medical College of Chicago in 1898, and was a member of the Grant County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association, and was serving as secretary of the City Board of Health of Marion at the time of his death.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in The Journal of The Indiana State Medical Association. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

The Eighteenth Clinical Congress of the American College of Surgeons will be held in Boston, October 8 to 12, 1928.

Dr. Frederick E. Jackson, of Indianapolis, has been made head of the Indianapolis City Health Board, succeeding Dr. E. E. Padgett.

Dr. Walter F. Kelly has been selected to fill the unexpired term of Dr. Arthur E. Guedel, for the Board of Public Health of Indianapolis.

The Northwestern Ohio District Medical Association will hold its eighty-fourth meeting at Memorial Hall and Barr Hotel, Lima, Ohio, October 9, 1928. Dr. J. V. Pace, Lima, will supply information to interested Indiana physicians.

The Ohio Valley Medical Association will hold its meeting in Evansville, with headquarters at the McCurdy Hotel, November 14 and 15, 1928. The secretary, Dr. Bruce H. Beeler, Evansville, will be pleased to communicate with Indiana physicians who desire to present papers at the meeting.

Dr. and Mrs. Fletcher Hodges recently attended the graduation of their son, Fletcher Hodges, Jr., who received an A. B. degree from Harvard in June. Dr. Hodges also attended the meeting of the Harvard Medical Alumni Association at Boston which was addressed by Dr. William E. Thayer.

The U. S. Civil Service Commission announces open competitive examination for junior medical officer (interne) applications for which must be on file with the Civil Service Commission at Washington, not later than December 29. Examination is to fill vacancies in the U. S. Veterans' Bureau Hospitals throughout the United States.

The U. S. Civil Service Commission announces open competitive examination for Social Worker (psychiatric) and Junior Social Worker, to fill vacancies in the U. S. Veterans Bureau. Applications must be on file not later than December 29. Complete information and application blanks may be obtained from the U. S. Civil Service Commission, Washington, D. C.

THE United States Civil Service Commission announces open competitive examinations for Senior Medical Officer, Medical Officer, Associate Medical Officer and Assistant Medical Officer. Applications will be rated as received until December 29, 1928. Information concerning the examinations may be obtained by writing to the United States Civil Service Commission at Washington, D. C.

THE U. S. Civil Service Commission announces open competitive examinations for Occupational Therapy Aide for arts and crafts, trades and industries, gardening, horticulture and floriculture, occupation therapy pupil aide (trades and industries) and Occupational Therapy Assistant (trades and industries). Applications will be rated as received by the U. S. Civil Service Commission at Washington, D. C., until December 29, 1928.

THE members of the Staff Society of the Indianapolis Methodist Hospital were entertained at a picnic at Forrest Inn, Noblesville, Indiana, Wednesday afternoon and evening, August 15, 1928. Golf, cards, swimming and other entertainment was provided for all who attended. A chicken dinner was served at 7 o'clock. Prizes were awarded for golf and for the card games. Dr. Marie Kast was general chairman of affairs, assisted by Dr. Lyman Pearson, Dr. and Mrs. William Gabe and Dr. L. N. Mueller.

THE eighteenth clinical congress of the American College of Surgeons will be held in Boston, October 8 to 12, 1928. Headquarters will be at the Statler Hotel and meetings will be held in the ballroom of the Copley-Plaza Hotel and Symphony Hall. The hospital standardization conference will be held in the morning and afternoon sessions in the ballroom of the Copley-Plaza Hotel, Monday, Tuesday, Wednesday and Thursday. An innovation this year will be the commencement of the clinics in the Boston Hospital on Monday afternoon, continuing through the mornings and afternoons of the following four days. Reduced railway fares on the railways of the United States and Canada have been authorized to those holding a convention certificate so that the total fare for the round trip will be one and one-half the ordinary first class one-way fare. The chairman of the Boston Committee on Arrangements is Dr. Frederick J. Cotton.

THE Indiana University School of Medicine has made the following additions to its faculty: Dr. Albert E. Bulson, Jr., has been made head of the department of Ophthalmology. Dr. W. H. Kennedy, Associate in Medicine (radium therapy); Dr. Gerald W. Gustafson, Assistant in Obstetrics; Dr. Edwin Lee Libbert, Assistant in Medicine; Dr. Walter P. Morton, Assistant in Genito-Urinary Surgery; Dr. John Moore Taylor, Assistant in Dermatology and Syphilology; Dr. Walter B. Tinsley, Assistant in Dermatology; Dr. George Wood, Assistant in Gynecology; Dr. Joseph J. Littell, Assistant in Rhinology, Otology and Laryngology; Dr. Bert Edward Ellis, Dr. Guy Worthington and Dr. Henry W. Irwin, all Assistants in Rhinology, Otology and Laryngology. Dr. H. O. Mertz has been promoted from assistant to associate. The following professors at the University have died recently: Frank A. Morrison, John H. Oliver, O. G. Pfaff, William H. Foreman, Samuel E. Smith.

THE Annual Conference of State Health Officers of Indiana will be held at Gary, September 25 and 26, with headquarters at the Gary Hotel. The opening session of the conference will be held at 10 a. m. daylight saving time, Tuesday, September 25. This is the first time the conference has been held outside of Indianapolis and is being held at Gary this time on account of the State Medical Association meeting which will follow the Conference, beginning September 26, in the evening and continue through September 27 and 28. A program of unusual interest is being prepared and it is to be hoped that every county, city and town health officer in the state will make every effort to attend the Conference. In addition to the usual discussion of subjects connected with administrative public health work, the State Board of Health has arranged for a discussion of several subjects that are of special interest to health officers and to the medical profession. Surgeon Edward Frances of the U. S. Public Health Service will discuss undulant fever and its relation to infectious abortion in cattle. Surgeon Frances has made a special study of this disease and also of tularemia, and was awarded a gold medal by the American Medical Association at the Minneapolis meeting because of his outstanding work along this line. Dr. Samuel J. Crumbine, executive secretary of the American Child Health Association, will give an address on "The Lost Sixteen Thousand." Dr. Crumbine was State Health Commissioner of Kansas for a number of years before becoming the executive officer of the American Child Health Association and is recognized as one of the leaders in public health throughout the United States. A special feature of the program will be a demonstration of medical inspection and health supervision as carried out in the Gary Schools. This demonstration will be in charge of Dr. Otis B. Nesbit, Chief Medical Director, and William A. Wert, Superintendent of the Gary Schools. There should be a large attendance of health officers at this Conference not only because of the excellence of the Conference program, but also because of the opportunity to attend the meeting of the Indiana State Medical Association at the same time.

Registration and headquarters of the Conference will be at the Gary Hotel.

In addition to the usual discussion of subjects the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Chicago Dietetic Supply House:

Cellu Soy Bean Flour.

Cellu Soy Crisp.

Mead Johnson & Co.:

Mead's Powdered Boilable Lactic Acid Milk.

Parke, Davis & Co.:

Cotton Protein Extract Diagnostic—P., D. & Co.; Cottonseed (Cake) Protein Extract Diagnostic—P., D. & Co.; Goat Hair Protein Extract Diagnostic — P., D. & Co.; Human Hair Protein Extract Diagnostic—P., D. & Co.; Kapok Protein Extract Diagnostic—P., D. & Co.; Peptone Protein Extract Diagnostic—P., D. & Co.; Poplar Pollen Protein Extract Diagnostic—P., D. & Co.; Sunflower Pollen Protein Extract Diagnostic—P., D. & Co.; Sweet Vernal Grass Pollen Protein Extract Diagnostic—P., D. & Co.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

July 16, 1928.

Meeting called to order at 4:45 P. M.

Present: Wm. N. Wishard, M.D., Chairman; J. A. MacDonald, M. D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held July 9 read and approved.

The release, "Chiggers," read and approved for publication Saturday, July 21.

Report was made that radio talk upon "Sunstroke," prepared by the Bureau, was given over Station WFBM Saturday, July 14.

The release upon "Chiggers" is to be given over Station WFBM Saturday, July 21.

Report of medical meeting:

July 13—Carroll County Medical Society, Rockfield, Indiana. (Bureau was called upon to obtain speaker at last minute due to an emergency.)

Meetings to be held:

July 26—Grant County Medical Society, Marion, Indiana. Speaker to be obtained.

July 30—Lions Club, Greenwood, Indiana. "Periodic Health Examinations." Speaker obtained.

August 27—Joint meeting of County Institute of Teachers and Parent-Teachers Association, Fowler, Indiana. Subject: "Infectious Diseases of School Children and Immunization from Smallpox, Diphtheria and Scarlet Fever." Speaker to be obtained.

Letter received from the Dean of the Medical School, Bloomington, Indiana, saying that he believes that a scientific exhibit in connection with the medical meeting would be worthwhile. The letter said in part, "I believe in the scheme you propose and would like to carry it out but do not see how I can do so this year. Another year I am hoping I can have more help and then will be glad to take part in the way you are suggesting."

The Bureau instructed the secretary to send a copy of changes made in the Indiana University School of Medicine faculty both to the Journal of the American Medical Association and the Journal of the Indiana State Medical Association.

Due to the fact that two very definite complaints from persons who had been fleeced by cancer quacks had been brought before the Bureau of Publicity in the last few months, the Bureau instructed the executive secretary to formulate a release upon cancer quacks and warn the public concerning the methods of these charlatans. The latest complaint is against Charles O. Ozias of Kansas City, Missouri. An Indianapolis woman called at the office saying that Dr. Ozias told her and her sister that they both had cancer, made them sign contracts which called for an expenditure upwards to $1,000,000 apiece and extracted a down payment from them of $250.00. Dr. Ozias, according to the report of this woman, represented himself as having a sanitarium near Kansas City. A pamphlet of the Defensive-Diet League of America in which there appears an article by Dr. Charles O. Ozias suggesting very strongly that Dr. Ozias can cure cancer, came before the Committee. The secretary was instructed to take the whole matter up with the Better Business Bureau of Kansas City, Missouri, and to get information from the American Medical Association upon the Defensive-Diet League and Dr. Ozias.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole July 23, 1928.

Wm. N. Wishard, M.D.,
Chairman.

Thomas A. Hendricks,
Secretary.

BUREAU OF PUBLICITY

August 20, 1928.

Meeting called to order at 4:45 P. M.

Present: Wm. N. Wishard, M.D., Chairman; M. N. Hadley, M.D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held July 16 read and approved.

A preliminary outline of the annual report of the Bureau was presented to the committee. The final draft of the report was to be prepared for approval at the next meeting of the Bureau.

The article—Protection against Typhoid Fever—was reviewed and passed for release on Saturday, August 25.

The following radio talks have been broadcast over station WFBM:

July 21—Chiggers.

July 28—Summer Care of Young Children.

Aug. 4—Children and Fear.

Aug. 11—Hot Weather Health Hints.

Aug. 18—Safe and Sensible Swimming.

Report was made upon the following medical meetings:

July 30—Lions Club, Greenwood, Ind. "Periodic Health Examinations."

July 26—Kiwanis Club, Laporte, Ind. "Rabies Prevention."

Aug. 2—Grant County Medical Society, Marion Ind. "Goiter."

Meetings to be held:

Aug. 21—Kiwanis Club, Bedford, Ind. Speaker obtained.

Aug. 27—Joint meeting of the Benton County Medical Society with the Teachers' Institute and the Parent-Teachers' Association, Fowler, Ind. Subject: "Infectious Diseases of School Children and Immunization from Smallpox, Diphtheria and Scarlet Fever." Speaker to be obtained.

Request was received from the Associated Press for an article upon Hay Fever.

The secretary was instructed to attend a meeting for the arrangement of Y. M. C. A. Health Exhibit Weeks to be held at Richmond, New Castle, Greensburg, Anderson, Fort Wayne, Lafayette, and other cities throughout the state. The head of the Physical Education work of the Y. M. C. A. for the state asks that this representative meet with the Committee at 10 o'clock, September 5, at the Indiana Central College.

A questionnaire entitled "The Activities in the Direction of Health Education of the Public" was received from the Executive Secretary of the Bureau of Health and Public Instruction of the American Medical Association with the request that the Bureau make suggestions it thought suitable. The Bureau approved the questionnaire and instructed the secretary to acknowledge the questionnaire and express approval of it.

The following letter was received:

"DEUTSCHE ZENTRALE
(German Central)
Fur
GESUNDHEITSDIENST DER LEBENSVERSICHERUNG E. V.
(Health Service of the Life Insurance E. V.)
Wissenschaftliche Leitung Berlin-Zehlendorf-West
(Scientific Division) Seestr. 47 *Tel. Gr Zehlendorf 4966
Dr. Med. O. Neustatter

18th July, 1928

Mr. Thomas A. Hendricks, Executive Secretary,
Indiana State Medical Association,
Indianapolis, Ind., U. S. A.
Dear Mr. Hendricks:

It was with great interest that I read through your notes on the preparation of your releases. One sees the clever journalistic understanding of the psychology of the people and of the technical side from how you have organized the communications to the press.

I should be very pleased indeed to get from time to time all the articles that you are preparing for distribution to the press.

As it may interest you I am enclosing copy of a leaflet on tuberculosis which is just being sent out in over 600,000 numbers to the policy holders of different companies.

Thanking you again for your extensive reply, I am,
Yours sincerely,
(Signed) Otto Neustatter."

The following letter received from the Director of the Division of Infant and Child Hygiene in regard to Child Health Week at Winona Lake:

Your letter of July 10 came while I was at Winona Lake. I appreciate very much your placing before the Publicity Bureau of the Indiana State Medical Association the program which we were presenting at Winona Lake.

"I do not recall any occasion when the name of a local doctor has been given publicity in giving demonstrations, in fact, the physicians on our staff make practically all the examinations except in emergencies where the number of children is too great. We merely asked the Medical Society as a group for their moral support and the influence of their approval.

"We have always, in the approximately 50,000 children which we have examined, referred them to their family physician for supervision, as I hope the physicians throughout the state will testify. I cannot understand why there should be any opposition to child health week as to publicity given physicians. However, the decision rests with the Indiana State Medical Association and we are glad to know what they think about it.

"The program at Winona Lake this year was the most successful that we have ever had. Our physicians gave all the forenoon lectures, excepting the one when I was in New York, which was given by a local dentist, Dr. Wagner. The Friday afternoon program was of unusual interest. Many co-operative plans for child health programs were reported and I believe everyone there benefitted greatly by the meeting.

"This was not a county demonstration at Winona. We have given a Child Health week there every year for the last eight years. We feel, however, since Winona Lake is located in Kosciusko county that if the service we are giving can be extended to benefit the entire county, that is desirable.

"This year the county nurse appointed committee women in every township who were to tell parents of the child health conference. People who come to Winona Lake are likely to be those who have children under supervision in their own homes and who wish to have them checked over while they are there. We have not checked over the report this year but in the past year's examinations were made of children from thirty Indiana counties and eleven or twelve different states. So as you can see it is much more than just a Kosciusko county program.

"The Winona Lake management regards child health week as part of the Chautauqua and feels that the interest in the services given is one of the most valuable features that they have.

"Hoping that this explanation will make clear the work of this department during Child Health week at Winona Lake, I am....."

The following bills were approved for payment:

Indiana Bell Telephone Co.	$.35
Central Press Clipping Service	5.10
Bailey Office Supply Co.	15.00
Thurman B. Rice, M.D.	22.24
	$42.69

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole August 27, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

WOMAN'S AUXILIARY

During the meeting of the Indiana State Medical Association in Gary, September 26th to 28th, the hours from three to five on Wednesday afternoon have been assigned to the Woman's Auxiliary. At this time the organization of the State Auxiliary will be completed by the adoption of the constitution approved at an executive board meeting in May; reports will be given by presidents of county auxiliaries, followed by election of officers.

It is the custom at meetings of the National Auxiliary to hear the president and president-elect of the American Medical Association. In keeping with this, Mrs. Cregor is establishing a precedent for the Indiana Auxiliary by inviting Dr. George Daniels, president of the Indiana State Medical Association, and Dr. C. E. Gillespie, president-elect, to greet the assembled women. Guests of honor will be Mrs. Morris Fishbein, of Chicago, wife of the editor of the *Journal of the American Medical Association*, and Mrs. G. Henry Mundt, president of the Woman's Auxiliary of the Illinois State Medical Association. Both women retain interest in their native state, Indiana.

As one of the purposes of this Auxiliary is to promote friendliness among physicians' families, it is hoped that this spirit will be markedly manifest during all the gatherings which the Gary committee, with Mrs. O. C. Wicks as chairman, has provided for the entertainment of the women of the Indiana Auxiliary.

Respectfully submitted,
MRS. F. W. CREGOR, President.

CORRESPONDENCE

DRUG DISPENSING BY PHYSICIANS

Mitchell, Indiana.
August 18, 1928.

Editor of THE JOURNAL:

I note your editorial comment on the large number of physicians who are drug dispensers. There is a reason for drug dispensing by physicians, for they are forced to it in self-protection. As physicians we have popularized certain pharmaceutical specialties, and the druggist prescribes them in place of the physician. The pharmaceutical associations condemn the dispensing physician, and I have read articles in *The Journal of the National Association of Retail Druggists* in which it was stated that the average physician is not competent to make a diagnosis nor dispense medicine. I never have seen a word in such journal about the fellow who runs a soda fountain for three or four years in a drug store, then goes before the State Board of Pharmacy and receives a certificate as a licensed pharmacist. I do not condemn the legitimate pharmacists who do not prescribe over the counter, but they are so few in number that one is a curiosity. I would rather write prescriptions altogether if the druggist will send the patients to physicians instead of prescribing for them themselves. Recently I was in a drug store and a young mother came in with a child who, according to her notion, had worms. Her description of the symptoms was that the child got white around the mouth and gritted his teeth during sleep. Upon being asked his opinion the drug clerk said that the child had worms and that he would prescribe for him, which he did by giving some kind of tablets. In explanation of his conduct he stated that if he didn't prescribe for the child some other clerk would, and then the sale would be lost.

Seldom does a drug clerk refuse to prescribe for any patient asking for something to relieve him of physical distress of any kind. Probably not once in twenty times is the diagnosis correct, nor does the remedy prescribed prove beneficial, but the prescribing goes on just the same. I venture to say that all of the dispensing physicians would stop dispensing and write prescriptions if the druggists would quit counter prescribing. Then, one of the worst offences charged against druggists is using a doctor's prescription for others, either through the act of the drug clerk in prescribing on his own diagnosis, or filling a prescription that has been peddled around the neighborhood. Prescriptions are written to cover a certain indication at a specified time, and are not intended for other patients nor for even the patient to whom it is given except for the time when given. Refills should be on the order of the physician only. Physicians in self-defense have learned to dispense their own drugs in order to get away from the refill, and this in justice to patient as well as physician. Dispensing on the part of the physician will continue until the druggist quits counter prescribing and refilling prescriptions without orders.

Respectfully,
JOHN A. GIBBONS, M.D.

CONCERNING ROTTEN MEDICAL ADVERTISING IN NEW YORK

Rochester, N. Y.
August 10, 1928.

Editor THE JOURNAL:

A copy of your July issue was sent to the Board of Health of this city. I thought you would be interested in the reaction so enclose letter received.

F. M. WILLSON.

Rochester, N. Y.
July 25, 1928.

Mr. F. M. Willson,
Better Business Bureau of Rochester, N. Y.,
1241 Lincoln Alliance Bank Building,
Rochester, New York.

My Dear Mr. Willson:

I am interested in what the Journal of the Indiana State Medical Association has to say about the advertisements in the New York State Journal of Medicine. I have felt so strongly about the matter and the bad character of much of the advertisements, that I have written them in protest but they do not care, all they want is the income.

The Medical Society of the State of New York issues a medical directory advertising Kalak Water on one side and Antiphlogistine on the other. More than once I have torn the cover off and sent it back to them and told them I would not have such a book about the office.

I know of no journal with any pretense of decency that carries such a lot of advertisements of the character carried by the New York State Journal of Medicine. They are so bad that I have often thought of resigning as a protest against the character of the advertisements which they carry in the journal.

I am going away for the month of August. I will be glad to talk with you further about this matter when I return in September.

Very truly yours,,
G. W. GOLER, M.D.,
Health Officer.

WHAT PRICE HOSPITAL STANDARDIZATION?

Indianapolis, Indiana,
August 18, 1928.

To the Editor:

This is the era of development of hospitalization for most illnesses. The many varieties of demands of many doctors have no doubt driven the administrative departments of hospitals to a state of mind where the appearance of any form of standardization is very welcome. Opportunely, the American College of Surgeons comes out with a plan for standardization and classification of hospitals. The staff doctors of our hospitals strive to help the hospitals reach class A. In the meantime some rather vital features concerning the patient and his illness have been overlooked in the scramble towards Utopia.

Let us reflect a little and remember a few dogmatic premises. Primarily the hospital is an instrument of the doctor through which he may better combat a pathologic condition of the patient. Its hope is to serve the doctor well. Its discipline should be aimed at giving the doctor complete co-operation. The doctor's word should be unquestioned law in the sick room or in the surgery. Why all this? Simply because there is but one person responsible for the patient—the doctor. If the doctor cannot bear the load he should sell insurance—but not to me.

Of course it is good to have hospital staffs by which the wheat can be separated from the chaff, but there is so much rot in the best of us that it is hard for the best of us to tell just who is the worst of us. Or should that be put the other way around? However, the police function of a staff is but a minor thing compared with the present miscarriage of the professional aim. Who on earth today expresses less satisfaction with his lot than the doctor? Where is the pride he should take in his knowledge, ability and opportunity? Without this pride he can have but little authority, or deserve it. Yet to allow the assumption of this authority by an outsider, one who has no responsibility (medical, not legal) is to allow this outsider to assume the other attributes that should go solely to one of our profession.

First and foremost to all of us comes the patient's illness. To deal with this requires the exercise of knowledge, skill and authority by the physician in charge. The physician in charge will direct the available cohorts along the line of investigation necessary to satisfy his particular questions. This must be done as he desires. The nurse is responsible to him in carrying out his orders to the letter, and in the common sense care of the patient.

The hospital should be an ideal hotel for the sick. Does the College of Surgeons believe all this? Apparently not for it would standardize the treatment of diseases.

Some routine procedures are fine, and we all agree should remain routine, but the thing can be overdone. A leukocyte count on afebrile elective surgery is bosh at three dollars a count. But it is not as vicious as taking the blood pressure immediately prior to the induction of anesthesia for the removal of a toxic goitre. (To retain your popularity you smile and hope that your toxic case will not be disturbed too much.) That rare gift of intelligence on the part of associates sometimes helps us over these difficulties, but the point is that authority should not be invested in associates of the other sort who will exercise that effort toward the retention of popularity

Likewise, this business of histories can be overdone. Where the history is of no aid, as for instance in the removal of a fibroid uterus, why not leave it to the surgeon to find out for sure that it is not pregnancy? It is his responsibility. Without going into too much particulars for fear of detracting attention toward said particulars and away from the point in mind, is it not evident that many of the requirements put on the hospital by the College in question are in the way of putting the hospital in the position of consultant in every case admitted? This should not be so as long as doctors are true to their profession. If one is found not to be, the police function of the staff can function and that ends that.

The truth of the matter is that the hospital must take pride in service rendered, and get away from the thought of entering actively into the fight against pathology. Who in the personnel of a hospital is fit to act as an advisor on all cases, as one should be if the hospital is to enter the field as a consultant? And yet that is the ultimate target reached by continuance of the College standardization idea. That brings up a thought.

The College inspects the hospital and classifies it according to report from the inspector. Now is it not true that such an inspector should be one of great experience, so that he might be in a position to judge just how efficiently the hospital is co-operating with the physician? Offer a man of that stamp such a job and see how far you get. We all know what type has the time and inclination for inspecting, and we therefore know just how valueless that opinion is in helping a local situation in the treatment of disease. That explains how it is that one institution can give its staff a whole lot of indifferent service and yet retain a class A rating by having its paper work done completely.

In line with this, the inspector type of man will butter his bread and curry favor from the administrative end of the hospital by paying much attention to red tape and reports and grade accordingly. As he has no experience and therefore can not know, he pays little attention to those services rendered the patient by the hospital which pertain to the recovery of the patient. In fact, I am reminded of the labor agitator who has never done manual labor. In this case, the agitator sides with the hospital executives, thereby beginning a division of thought and perhaps giving rise to friction where a most pleasant spirit of co-operation might have been developing. That eventually means more paper work for us. Does that help in the treatment of disease? Of course not.

Should we not ask the following questions to reach a real conclusion? What is the need for adoption of a foreign standardization? How has the treatment of disease been aided by standardization? How much has the patient profited in the way of getting more for his money by the adoption of this standardization? Were our local needs considered in the rules sent us? With what virtue or authority was the originator of this standardization idea possessed that enabled him to perpetrate it on us?

I do not want to appear to be bolshevistic, but the idea has occurred to me that we may be hanging on to the tail of a "bum" steer and that if we are not careful we will find that we are breeding a new class of standardized consultants, and that we will burn our fingers in the fire of standardized treatment—than which there is nothing more to be abhorred, or less sensible.

T. B. NOBLE, Jr., M.D.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books received since August 1, 1928:

BACTERIOLOGY FOR NURSES. By Charles F. Carter, B.S., M.D., director, Terrell-Carter Laboratory, Dallas, Texas. 214 pages. Illustrated. Cloth. Price $2.25. St. Louis. C. V. Mosby Company, 1928.

DIABETIC MANUAL FOR PATIENTS. By Henry J. John, M. A., M. D., F.A.C.P., director of Diabetic Department and Laboratories of the Cleveland Clinic. 200 pages. Illustrated. Cloth. Price $2.00. C. V. Mosby Company, St. Louis, 1928.

ULTRAVIOLET RAYS IN THE TREATMENT AND CURE OF DISEASE. By Percy Hall, M.R.C.S. (Eng.) L.R.C.P. (Lond.). 236 pages. Illustrated. Cloth. Price $4.50. C. V. Mosby Company, St. Louis, 1928.

RECENT ADVANCES IN CHEMISTRY IN RELATION TO MEDICAL PRACTICE. By W. McKim Marriott, B.S., M.D., Dean and Professor of Pediatrics, Washington University School of Medicine. The book includes lectures of the San Diego Academy of Medicine, Series of 1927. 140 pages, illustrated. Cloth. Price $2.50. C. V. Mosby Company, St. Louis, 1928.

BLOOD AND URINE CHEMISTRY. By R. B. H. Gradwohl, M.D., director of Gradwohl Laboratories, St. Louis, and Ida E. Gradwohl, A.B., instructor in Gradwohl School of Laboratory Technic, St. Louis. 542 pages with 117 illustrations and 4 color plates. Cloth. Price $10.00 The C. V. Mosby Company, St. Louis. 1928.

MODERN MEDICINE. Edited by Sir William Osler, Bart. M.D., F.R.S., etc. Third edition, thoroughly revised and re-edited by Thomas McCrae, M.D., Professor of Medicine in Jefferson Medical College, Philadelphia, and Elmer H. Funk, M.D., Clinical Professor of Medicine, Jefferson Medical College, Philadelphia. Volume VI. Including Diseases of the Nervous System, Diseases and Abnormalities of the Mind. 954 pages, illustrated. Cloth. Price, $9.00. Lea and Febiger, Philadelphia, 1928.

TREATMENT OF DIABETES MELLITUS. By Elliott P. Joslin, M.D., (Harvard) M.A., (Yale), clinical professor of medicine, Harvard Medical School. Fourth edition, revised and rewritten. 998 pages, illustrated. Cloth. Price $9.00. Lea and Febiger, Philadelphia, 1928.

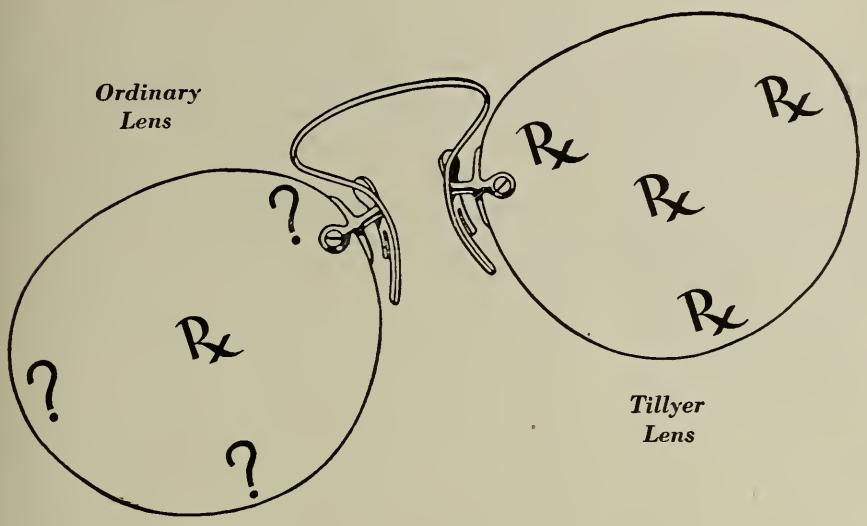
THE OPIUM PROBLEM. By Charles E. Terry, M.D., and Mildred Pellens. 1042 pages. Cloth. Written for and published by the Committee on Drug Addictions in collaboration with the Bureau of Social Hygiene, Inc., New York, 1928.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

PAROIDIN.—PARATHYROID EXTRACT—HANSON.—An aqueous solution containing the active principle or principles of the parathyroid gland of cattle and having the property of relieving the symptoms of parathyroid tetany and of increasing the calcium content of blood serum. It is standardized by its capacity to increase the blood serum calcium in parathyroidectomized dogs. Paroidin is of pronounced and definite value in the treatment of

(Continued on adv. p. xx)



TO OCULISTS:

THERE is a Boston optician who said to us not long ago: "Tillyer lenses have made it a pleasure to be an optical dispenser. Former wearers of glasses tell us about the increased clarity and new wearers don't have to 'get used to' glasses."

You yourself ought to try Tillyer lenses in your own glasses. See how much better vision *you* can have when your prescription is followed as accurately in the margins as the center, and when your lenses are polished in the same way that fine camera and telescopic lenses are polished.

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AMERICAN OPTICAL COMPANY

TILLYER LENSES

Accurate to the very edge

TRUTH ABOUT MEDICINES

(Contiuued from page 426)

tetany. To guard against the serious consequences of hyperthyroidism, excessive doses of paroidin must be avoided and large doses of the preparation must not be administered without estimation of the blood serum calcium. Paroidin is marketed in 5 cc. ampules, each cc. containing 150 Hanson units, Parke, Davis & Co., Detroit.

Squibb's Vitavose.—A maltose-dextrin preparation representing the water-soluble extractives of malted wheat germ. It is composed, approximately, of maltose, 38 per cent; dextrins, 20 per cent; soluble proteins, 8 per cent; soluble amino and other nitrogenous substances, 7 per cent; mineral salts, 4 per cent; moisture, 3 per cent. It is standardized physiologically to contain at least 100 times the amount of the antineuritic factor (vitamin B) contained in fresh, raw, certified, whole cow's milk. Vitavose is used as an adjunct in the diet of children and invalids and where there is a need for greater amounts of vitamin B than are furnished by the individual's customary diet. E. R. Squibb & Sons, New York.

Gentian Violet Capsules—Swan-Myers, 1 grain. —Each keratin coated capsule contains gentian violet medicinal (New and Nonofficial Remedies, 1928, p. 172) 0.65 Gm.; with lactose. Swan-Myers Co., Indianapolis.

Capsules Ephedrine Hydrochloride—Pemco, ¼ grain.—Each capsule contains ephedrine hydrochloride—Pemco (New and Nonofficial Remedies, 1928, p. 176) ¼ grain. Prophylacto Mfg. Co., Chicago.

Capsules Ephedrine Hydrochloride—Pemco, 0.3 Gm.—Each red capsule contains ephedrine hydrochloride —Pemco (New and Nonofficial Remedies, 1928, p. 176) 0.3 Gm. Prophylacto Mfg. Co., Chicago. (*Jour. A. M. A.*, July 7, 1928, p. 28).

PROPAGANDA FOR REFORM

Vitalipon Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that Vitalipon is claimed to be a 5 per cent solution of olive oil of lipoids extracted from vegetable and animal embryonic organs with the addition of cajeput oil. Consideration of Vitalipon was requested by C. G. Crosby, New York. In the material submitted in favor of Vitalipon, the statement was made that "Vitalipon is the outcome of over thirty years' research work by Dr. O. Schaer of Zurich, Switzerland, in his efforts to develop a cure for carcinoma." In addition to the brief statement of composition, uses, etc., submitted by C. G. Crosby, three documents written by Dr. Schaer were also submitted The Council found Vitalipon unacceptable for New and Nonofficial Remedies because it is an unscientific and indefinite mixture marketed under an uninforming proprietary name and with unwarranted therapeutic claims. (*Jour. A.M.A.*, July 7, 1928, p. 29).

Diphtheria Toxoid.—In the hands of Ramon and his co-workers in Paris, diphtheria toxoid has given satisfactory results in the prevention of diphtheria. According to reports it is being used on a large scale in France. The obvious advantage of diphtheria toxoid over antitoxic serum is that toxoid does not contain any protein of any foreign animal species. The H. K. Mulford Co. is supplying the product and has requested its consideration by the Council on Pharmacy and Chemistry. (*Jour. A.M.A.*, July 7, 1928, p. 45).

Combinations of Cod Liver Oil and Phosphorus Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that the use of elementary phosphorus in the treatment of rickets is based on the observations of Wegner in 1874, that the administration of white phosphorus in minute amounts caused the formation of a dense band at the epiphyses of the long bones. Subsequently conflicting reports as to the value of phosphorus in rickets were published. Death occurred in several instances from excessive doses of phosphorus. Practically all those claiming to have obtained good results from the use of phosphorus used it in combination with cod liver oil (now known to be a specific in rickets). The accumulated evidence is unconvincing as to the value of phosphorus; furthermore, it is known that phosphorus is a dangerous drug and the routine administration of phosphorus in combination with cod liver oil is to be discouraged. In consideration of the new evidence and the opinions based thereon, the Council decided that preparations of cod liver oil containing phosphorus are unacceptable for New and Nonofficial Remedies as being unscientific and inimical to the best interests of the public and the medical profession. The Council decided to omit from New and Nonofficial Remedies all mixtures containing phosphorus in combination with cod liver oil. (*Jour. A.M.A.*, July 14, 1928, p. 97).

The Iron Content of Foods.—As a carrier of oxygen and as an activator of cell functions, iron has significance out of all proportion to the amount in the body —less than a tenth of an ounce, or the weight of a cent. The function of iron in the body has been responsible for considerable pseudo science and actual quackery. The bill-boards have sounded the call to have one's iron day by day. As regards the possibility of a shortage in the iron intake through food, Sherman states that the typical American dietary does not furnish any such surplus of iron as would justify the practice of leaving the supply of this element entirely to chance. Rather, foods should be selected with some reference to the kinds and amounts of iron compounds which they contain. Arranged in descending order as to their iron content, as determined by recent analyses, the classes of foods come as follows: dried legumes, green leafy vegetables, dried fruits, nuts, cereals, poultry, green legumes, roots and tubers, non-leafy vegetables, fish and fruits. Different samples of the same food material show great variations in their iron content. Cabbage, celery and head lettuce, vegetables containing little chlorophyl, were found to be low in iron. Salt water fish contain more iron than fresh water fish. Fish with dark-colored tissue contain more iron than those with light-colored tissue. The dark meat of poultry is likewise higher in iron that the light meat. (*Jour. A.M.A.*, July 28, 1928, p. 250).

Urasal Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that Urasal (Horner) is offered with the following indefinite and nonquantitative statement of composition: "Urasal (Horner) Granular Effervescent Contains: Hexamethylenamine, Pierazine, Lithia and Acid Benzoic in proportionate combination." The information sent the Council stated that Urasal contained "to each average dose of one dessertspoonful 7½ gr. Hexamethylenamine, 2 gr. Lithia Benzo Citrate and 1 gr. Piperazine Tartrate." Information in regard to the composition of "Lithia Benzo Citrate" was not supplied nor was the weight of the product represented by "one dessertspoonful" stated. The Council reports that the preparation is "Recommended in the treatment of Rheumatism, Gout, Cystitis, Uric Acid, High Blood Pressure and all Affections of the Biliary Tract" and that the circular wrapped with the trade package paints an exaggerated picture of the toxemia brought about by intestinal stasis. The Council also points out that the advertising quite ignores the now generally accepted limitations of the effects obtained by the administration of hexamethylenetetramine (methenamine, U. S. P.) and ignores the fact that piperazine has been generally discarded. The Council found Urasal (Horner) unacceptable for New and Nonofficial Remedies because it is an unscientific mixture of indefinite composition, marketed under a name which is not descriptive of its composition but therapeutically suggestive instead; and because it is marketed with unwarranted therapeutic claims in a way which will lead to its indiscriminate and ill-advised use by the public. (*Jour. A.M.A.*, July 28, 1928, p. 247).

THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION

DEVOTED TO THE INTERESTS OF THE MEDICAL PROFESSION OF INDIANA

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ORIGINAL ARTICLES

PRESIDENT'S ADDRESS*

THE INDIANA STATE MEDICAL ASSOCIATION

GEORGE R. DANIELS, M.D.

MARION

Members and Guests of the Indiana State Medical Association:

It is with sincere fraternal spirit that I desire to thank the members of the Indiana State Medical Association for the honor of serving as president of the Association during 1928.

This is the seventy-ninth annual session, and I do not doubt that the scientific program which is to be given has been arranged with the same idea dominant that those in charge of the first session had when they arranged for a program of special interest to the general practitioners, who I believe are the members who should be considered first, as in their work they must cover the whole field of medicine and surgery. However, I have no criticism to offer concerning former programs nor advice to offer concerning future programs.

Having been a regular attendant and in close touch with the Association for many years I can not help feeling proud of our Association's activities, and the good fellowship that prevails. I feel sure that activity, interest, enthusiasm and a sincere desire for co-operation was never as great as it is at this time. No matter what service has been demanded, the members have responded whenever called. Our Association is on a par with the best in the country and is so regarded by other state societies.

It would be impossible in a short address to enumerate and comment upon all the things that are being accomplished by our Association, though I desire to offer a few comments concerning some of the Association's activities. Our officers and committees all are functioning in splendid fashion as are the different officers.

THE JOURNAL ranks very high. I believe it to be the best state journal in the United States, and I wish to congratulate the editor on such a splendid achievement.

We are fortunate in having the services of a most efficient executive secretary whose methods and conduct in office are being imitated in other states.

This is the age of super-commercialism which measures everything by the dollar and cents standard. Hence, it seeks to prove all questions by arithmetic, so it easily has been deduced that public health is public wealth, and that people hunger for advice upon disease prevention. Your Committee on Publicity is doing wonderful things for us and a great deal more for the general public in providing health education. In its scope it furnishes good speakers who spread advice to hundreds, and it is reaching thousands with well prepared articles in the daily press. The purpose of articles on medical subjects is plain. It is an attempt to supply the public with authentic information. The data supplied deals with generalities alone, as it makes no attempt to prescribe, and it interdicts the mention of particular medication and dosage. Throughout, the suggestion is made both by word and inference to consult a competent physician. It alienates the public from the cult and quack, it counteracts the garbled information which comes from the cultist propaganda, quack advertising and the well intentioned efforts on the part of newspaper reporters to abstract articles in medical journals. Information gained from such sources often is untrustworthy, sensational or untrue. The committee in charge of this work is composed of men having broad vision, and they are not afraid of hard work as they labor many, many hours in perfecting these bulletins.

Medicine has numerous and varied relationships to the community and individual health, and those relationships have certain implications in medical education. An attempt even to name them must acknowledge at once the fundamental basis of modern medicine and its hope for the future, namely, scientific discovery. There can be no doubt that the present knowledge of the causes and life history of disease and the methods of diagnosis, treatment and prevention has increased more rapidly during the last forty years than in the previous four thousand years. The translation of this knowledge into practical terms not only has meant in one generation an increase of more than sixteen years in the expectancy of

*Presidential address delivered before the Gary session of the Indiana State Medical Association, September, 1928.

life, but has brought immeasurable happiness and comfort to millions of people. During the last fifteen years there has been a sixty to eighty per cent reduction in the death rate from such diseases as typhoid, malaria, diphtheria, tuberculosis and the intestinal diseases of children. Not only has there been this great reduction in mortality from these diseases, but there has been a large decline in the amount of illness and incapacity resulting from them. Great advances also have been made in surgery. So near perfection has become surgical technique that operative procedures no longer are dreaded and early operation prevents many deaths annually. Therefore, I feel that proper publicity to a commecialized people will bring happy results. The demands on the publicity committee for many speakers and bulletins attest the fact that the general public is pleased with the service. We are in the midst of a political campaign and I hope that doctors will exercise a privilege as well as perform a duty as true citizens, cast a ballot in the coming election. Vote for your choice. Of course, this being an age of bloc, I trust that you will remember our bloc, as our success in securing laws depends on friendly legislators in our state and nation.

We live to serve, but we serve to live. It is peculiar to the medical profession that it destroys its capital. The profession stands alone in this respect. There is not a physician who would not do all that lies in his or her power to prevent sickness, yet the cure of sickness is our business and from it we must reap our financial reward. We seek only legislation which will benefit the people as a whole and ask nothing selfish in return. After all we are an altruistic bloc and have only the health of the people in mind. I am firmly convinced that we were fortunate in getting a helpful measure through the last legislature, so let us prepare early for the session just ahead. I can reliably inform you that the cultists certainly are busy at this time. They are being marshalled largely by our esteemed contemporary finesse society, the League for Medical Freedom.

The State Association truly is dependent on the component societies. May I not ask that you give more assistance to your local society, at least to the extent of attending regularly? If you will do this we will have a better state association and a stronger profession throughout Indiana.

There is no rest for the physician because there is no rest in science. Science always progresses, and as the stars, we must go on unhastened, unresting and always at work.

I am grateful to the officers and all the committees for their unselfish assistance and especially the Lake County Medical Society that has prepared so generously for these occasions and our social entertainment in this splendid city, which is so young and yet is the beehive of the steel industry of the world.

Again I assure you of the pleasure and gratification I feel in being president of our State Association this year.

END RESULTS IN SURGICAL TREATMENT OF GALL BLADDER DISEASE*

M. N. HADLEY, M.D.
INDIANAPOLIS

Until recent years the problem of gall bladder surgery has been an attempt to determine what type of operation was most likely to result in a cure of the patient. For approximately forty years following the first cholecystostomy, performed by Dr. John Bobbs, drainage of the gall bladder has been done when resort to surgical therapy seemed necessary for the relief of symptoms due to disease of this organ. After a sufficient length of time had elapsed following the practice of gall bladder drainage, to make an accurate appraisal of end results, it has been found that such a method failed to cure in too large a number of cases to justify its routine continuance, so at the present time there appears to be hardly a lingering doubt as to the advisability of removing all gall bladders that require surgical treatment for the relief of symptoms.

Supplanting the question of the type of operation is the no less difficult one of a proper differentiation between the surgical and non-surgical group of gall bladder disease. If one is to judge by published statistics, there is a wide difference of opinion among surgeons as to what type of pathological or clinical picture constitutes a reasonable basis for surgical treatment. Deaver[1] reports in a recent series 47.2 per cent non-calculous gall bladders either removed or drained, whereas there was 16 per cent non-calculous gallbladders in the series herein reported. This difference in the ratio of calculous to non-calculous gall bladders treated surgically will be found in other clinics, although the ratio quoted above may mark the extremes of radical and conservative view.

In a considerable group of cases the situation is not unlike that of the appendix, wherein somewhat obscure right lower quadrant symptoms have led to the mistaken conclusion that this organ was at fault. When removed under such circumstances the appendix seldom fails to reveal certain pathological changes which are sufficient to warrant the pathologist in classifying the section as chronic appendicitis. It is evident that the same situation exists in the gall bladder. Very few normal gall bladders survive the fourth decade of life, if the pathologists' classification of a normal organ is to be taken as a criterion. It is evident, however, that neither in the case of the appendix nor the gall bladder can the milder

*From the Department of Surgery, Indiana University School of Medicine.

1 J. B. Deaver-Edward Bortz. Gall Bladder Disease. Journal of A. M. A., Vol. 88 PP. 619. February 26, 1927.

grades of inflammatory changes as shown by the microscope always constitute a reasonable surgical indication for the removal of these organs. This does not result from any difficulty the pathologist has in interpreting the tissue changes which have taken place as the result of infection, but rather is it a problem for the surgeon to translate a pathologic picture in terms of clinical symptoms. In the case of the gall bladder the problem is doubly complex because we are dealing with an organ of major importance for the proper functioning of the biliary system, and its removal cannot be considered except upon the assumption that its presence is a menace to the health or life of the individual.

It is obvious that an answer to this question can be obtained only by a careful study of the results of treatment in definite groups of cases. The following tables contain clinical data and the end results obtained in one hundred cases of gall bladder disease surgically treated, from the surgical service of the Indiana University Hospital.

Sex: Female, 82; male, 18.

Age Group: 20-30, fifteen per cent; 30-40, twenty per cent; 40-50, twenty-four per cent; 50-60, twenty-one per cent; 60-70, eighteen per cent.

Length of Symptoms.

1. Average length of symptoms	15 years
2. Shortest duration	3 weeks

Jaundice

1. History jaundice	44%
2. Not jaundiced	46%
3. Indefinite history	10%

Typhoid

1. Number giving history of typhoid	20%
2. Negative history for typhoid	62%
3. Charts failing to mention typhoid	18%

Chief Complaint of Patient

1. Epigastric pain referred to back and shoulders	25%
2. Right upper quadrant pain referred to back and shoulders	21%
3. Total number cases with referred pain	46%
4 Epigastric pain not referred	25%
5 Right upper quadrant pain not referred	14%
6. Total number cases in which pain is not referred	39%
7. Indigestion as chief complaint	4%

Pathology

1. Calculous cholecystitis, chronic or subacute	84%
2. Non-calculous cholecystitis, chronic	16%

Length of Hospitalization

1. Average	31 days
2. Shortest	15 days
3. Longest	125 days

Operative Procedure

1. Cholecystectomies	78%
2. Cholecystostomies	19%
3. Records failed to show	3%

Follow-up Record

Cured	79+%
Improved	16+%
Unimproved	4+%
Calculous gall bladders cured	84+%
Non-calculous gall bladders cured	72+%
In series as whole, gall bladders removed	80 %
In improved but not cured, gall bladders removed	50 %
Post-operative hernia	2 %

The above percentages are based upon one hundred consecutive follow-up records showing the results of operation two to three years following admission to hospital, and obviously cannot take into account the mortality rate, which is four per cent in the University Hospital in the five hundred sixty-eight cases operated since its opening.

The explanation of the rather high percentage of cured cases in this series as compared to others is, we believe, to be found in an analysis of the clinical type of gall bladder disease which came to operation. The chief complaint which brought the great majority of these patients to the hospital was the typical gall stone syndrome of repeated attacks of right upper quadrant pain frequently referred to back and shoulders, of which 86 per cent occurred in this group. Equally interesting is the fact that in the series 84 per cent were calculous gall bladders.

These percentages compared very closely with the total number of cured cases which, as noted above, was 79+ per cent. The end results in this series clearly indicate that the type of gall bladder disease most likely to get permanent and complete relief is that which is complicated by the presence of stones, and clinically are characterized by repeated attacks of right upper quadrant pain frequently referred to back and shoulders with accompanying gastric distress.

Analysis of Unimproved Cases

Case 1. The patient was a man forty-three years old, upon whom a previous gall bladder drainage had been performed elsewhere without relief of symptoms. He entered the hospital with complaint of epigastric distress and right upper quadrant pain associated with persistent diarrhea. He was in the hospital forty-one days, during which time complete laboratory and x-ray examinations were made all of which failed to contribute to a definite diagnosis. His gall bladder was removed, no stones were found. He reports no relief from symptoms.

Case 2. A man seventy years of age. His complaint was a sharp, persistent pain at right seventh and eighth costal border. Was in the hospital thirty-nine days. His symptoms had persisted three months; clinical and laboratory study failed to reveal the cause of his pain. Gall

bladder removed; no stones were found. He reports no relief from symptoms.

Case 3. A woman fifty-five years old. Chief complaint chronic dyspepsia. Had always been delicate. X-ray positive for stones. Gall bladder drained; stones found. Died three years later unrelieved of symptoms. Cause of death unknown.

Case 4. A woman whose chief complaint was recurrent attacks of epigastric pain radiating to back. No stones were found. Gall bladder removed. No relief from symptoms. Three years later returned to hospital, a duodenal ulcer found, was reoperated, pyloric resection was done with relief from symptoms.

Resume of Unimproved Cases. It is clear from a study of the charts of these four patients that the failure to get relief from symptoms following operation upon the gall bladder was due to a mistaken diagnosis. In only one of these cases was a calculous gall bladder found, and in this case the stones were of the so-called silent type, as the patient was a delicate woman whose symptoms of chronic dyspepsia persisted after the operation. Of the other three cases, all were non-calculous gall bladders; one had duodenal ulcer; one symptoms suggestive of intercostal neuralgia and the other chronic colitis.

Post-operative Hernia. There were two post-operative incisional herniae developed. One of them occurred in an oblique subcostal incision where the fibers of the rectus and external oblique were cut transversely. In this case an hemostat had been left on the cystic artery. A stone was removed from the common duct requiring additional drainage, and at this point a hernia subsequently developed. The other hernia developed where an additional incision had been made for the removal of the appendix and in which a coffer dam drain had been placed.

Analysis of Fourteen Improved But Not Cured Cases:

Hernia	2 Cases
Marked gastric distress	9 Cases
Recurrent attacks pain	2 Cases
Biliary fistula	1 Case

The cause of the herniae was unquestionably the amount of drainage used in the two cases, irrespective of the type of incision. While the majority of the incisions were the split upper right rectus, a considerable number were of the transverse type, cutting directly across the fibers of the rectus.

Of the nine cases reporting gastric distress, seven had calculous gall bladders. Relief from recurrent attacks of pain was obtained, but the associated gastric distress was of sufficient severity to regard themselves as not cured.

The two having a continuance of recurrent attacks of pain strongly suggest the possibility of overlooked common duct stones. The persistent biliary fistula followed the drainage of an enormous empyema of the gall bladder containing 4000 c. c. of pus. She later developed a duodenal fistula which was closed, but the biliary fistula persists.

Of major importance in the study of end results is the cause of failures. The four unimproved cases are clearly due to a mistaken diagnosis. This error will always account for a certain per cent of failures, and obviously should not be counted as a failure to cure in the surgical treatment of gall bladder disease. The average length of hospitalization was thirty-one days, indicating careful clinical and laboratory study before operation, which is essential in reducing the number of mistakes in diagnosis to a minimum.

In the improved but not cured group, in two cases the cause of failure was due to incisional herniae. These could have been avoided by an improvement in technique, wherein less bulky drainage would be needed. Unquestionably the dispensing with drainage entirely when possible, or drainage through a stab wound will lessen the incidence of hernia.

Marked gastric distress following operation accounted for the large majority of failures in this group. In this connection it is worth while noting that while in the series as a whole showing 79+ per cent cured, 80 per cent of the gall bladders were removed, in the unimproved but not cured group only 50 per cent of the gall bladders were removed.

This, indeed, seems to be the most striking difference between the cured and improved groups, and probably accounts for the failures to completely cure in a number of cases.

Two cases had recurring attacks of pain similar to those preceding operation, and suggests the probability of overlooked duct stones. In both cases stones were found and gall bladder removed. This accident will surely occur in any considerable group of cases unless care is taken to explore the common duct with a probe in cases showing a definite dilatation of the duct.

Conclusions Drawn From an Analysis of End Results:

1. Gall bladder disease complicated by presence of stones gives the highest percentage of cures when treated surgically.

2. Mistakes in diagnosis accounts for most complete failures.

3. Removal of the gall bladder gives a higher per cent of cured cases.

4. Gastric distress most troublesome post-operative complaint.

5. Post-operative hernia due to bulky drainage.

Acknowledgment is made to the Social Service Department of the University for assistance.

ABDOMINAL DIAGNOSIS AND THE UROLOGIST

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In order to minimize the chances of an unsatisfactory result or a failure after operations on the various intraperitoneal viscera, the general surgeon must never overlook the genito-urinary tract. A delay of a few hours in acute, and of a few days in chronic cases, does not jeopardize the patient's life and may avoid a useless operation The object of this paper is to direct attention to the help which a study by those specially trained

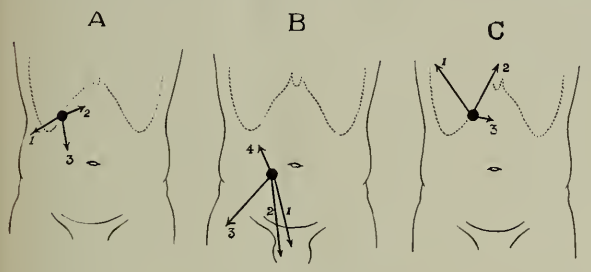


FIGURE 1.

Radiation of pain in acute pyelitis (A), in ureteral calculus (B) and in acute gall-bladder conditions (C). The figures and arrows indicate the directions in which the pain radiates, e. g. 1 in A shows radiation to back, 2 to right upper quadrant, and 3 towards midline. In B the most frequent radiation is along ureter towards testis or labia, thighs, and back (2, 3 and 4). In gall-bladder lesions the most frequent radiation is towards the right shoulder, as indicated by 1, next most common towards the left shoulder (2) and towards back (midline) as indicated by 3.

in the use of the cystoscope, passage of ureteral catheter and many other urologic diagnostic methods can give in clearing up abdominal cases presenting a typical finding.

I do not wish to be understood as advocating a complete urologic examination for every case presenting acute symptoms. Sufficient information can be obtained in a few minutes with plain radiography and ureteral catheterization in such acute cases to justify a delay of an hour.

More detailed examinations are indicated either when the acute symptoms have subsided or in cases which are seen in a quiescent period primarily. The urologist can be of service in the differentiation of the following intraperitoneal from reno-ureteral conditions:

1. Acute lesions of the biliary tract.
2. Chronic lesions of the biliary tract.
3. Acute appendicitis.
4. Chronic appendicitis.
5. Abdominal tumors.

Let us consider these briefly in the order named.

1. *Acute Lesions of the Biliary Tract*:

In this group and in the following one are included all inflammatory lesions of the extrahepatic biliary passages, whether complicated by calculi or not.

There are many cases of acute infections of the gall bladder, cystic and common ducts, with or without calculi, in which the diagnosis presents no difficulties. In these the pain is referred to the usual location of the gall bladder, viz., to the right upper quadrant (C of Fig. 1) and is accompanied by localized rigidity, tenderness and a variable degree of jaundice. Unfortunately, there are many cases in which these more or less pathognomonic findings are absent. One has only the history of severe pain, apparently of right upper abdominal quadrant origin. Rigidity is absent but on pressure there is tenderness.

Here the urologist's experience with acute lesions of the kidney and upper ureter is of value. In these the pain does not radiate to the shoulders as in biliary tract lesions. The pain either remains well localized and referred to the corresponding iliocostal space (this is the area between the last rib and the crest of the ilium) or it radiates towards the front (A of Fig. 1) of the corresponding upper abdominal quadrant or somewhat along the course of the ureter. On palpitation one often finds well-marked rigidity and tenderness over this iliocostal space (Fig. 2) especially at the costovertebral (the angle where the last rib meets the outer border of the erector spinae muscle) or renal angle. On bi-manual palpitation the kidney can usually be felt to be somewhat enlarged and tender. The urologist must keep in mind the following conditions in such a case:

(a) Acute blocking of the outlet of the renal pelvis or upper ureter by a calculus. (Fig. 3).

(b) Kinking of the ureter and torsion of the renal pedicle incidental to the "dropping" or descent of a kidney which is abnormally mobile

(c) Acute occlusion or blocking of the outlet of the renal pelvis or upper ureter by an anomalous vessel passing across the renal pelvis or upper ureter.

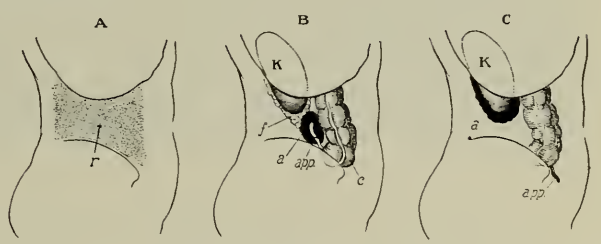


FIGURE 2.

Diagrams illustrating difficulties of differential diagnosis between retrocecal appendicitis and peri-nephric abscess.

A. Dotted area indicates extent of rigidity (r) over iliocostal space in both conditions.

B. Proximity of retrocecal appendiceal abscess to lower pole of kidney (right). C is cecum. App. is appendix. A is retrocecal abscess. F is peri-nephric fat.

C. Abscess (a) around lower pole of right kidney.

(d) Acute infection of the kidney or its surrounding fat, the former without calculi. (Since infection of the renal pelvis is invariably accompanied by a similar lesion of the parenchyma, the term pyelonephritis is now almost universally employed instead of the older one, pyelitis.)

Plain radiography will soon eliminate a calculus, although it must be kept in mind that about ten per cent of urinary calculi fail to give a shadow.

The uncertainty in regard to whether a calculus is present or not, can be rapidly solved by passing a ureteral catheter into the corresponding kidney. The immediate relief of pain, etc., and the rapid drop in temperature if there is accompanying infection, which follows the passage of such a catheter will enable one to make a diagnosis of some renal lesion with obstruction of the escape of urine. The more exact diagnosis of the character of the obstruction can be made later after the acute symptoms have subsided. We have found it very advantageous to leave the ureteral catheter *in situ* for several days to a week, in order to forestall the recurrence of the symptoms of acute ureterorenal block. In many cases the latter is due to a calculus which migrates from a dilated calyx and becomes fixed in the ureter or outlet of the renal pelvis completely occluding these. If one can pass such an obstruction with the ureteral catheter, the acute symptoms will only be temporarily relieved unless some provision for more prolonged drainage is made. At times the inlying catheter is either expelled or does not give sufficient drainage so that ureterostomy or pyelotomy are imperative with removal of an obstructing calculus or temporary relief for other forms of occlusion.

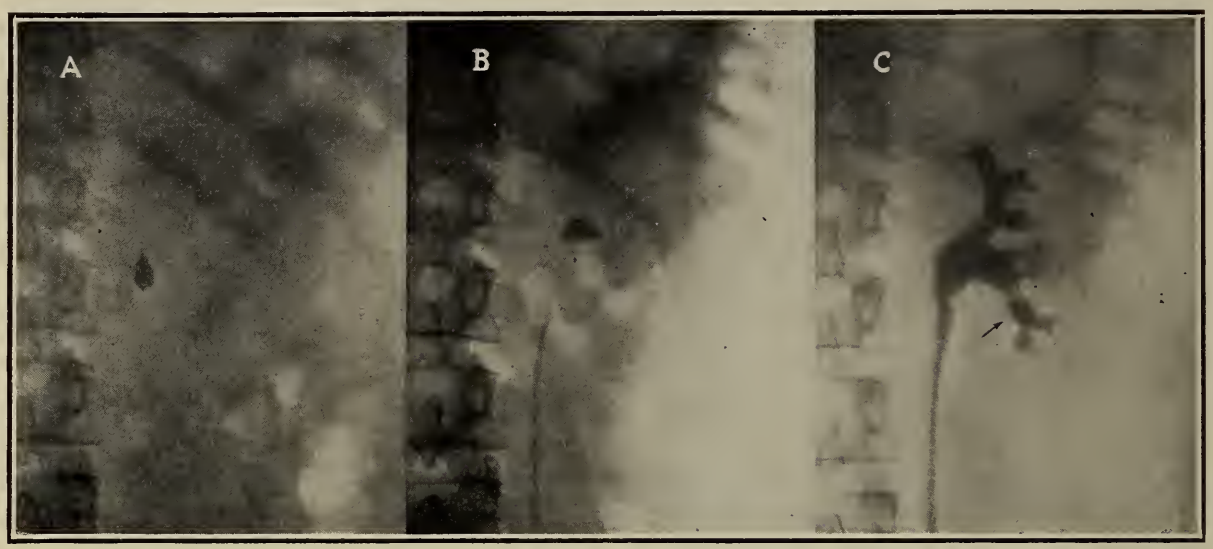


FIGURE 3.

A series of radiographs from case of migrating renal calculus complicated by acute pyelonephritis. A. Location of calculus at junction of ureter and renal pelvis during period of acute symptoms. The calculus completely prevents all drainage from kidney. B. Calculus has slipped back into renal pelvis during quiescent period. Free drainage from kidney pelvis is now possible. This exposure was made about one week after subsidence of acute symptoms, following use of inlying ureteral catheter. C. Pyelogram of same case. The arrow points to lower major calyx. The calculus was found in this location at operation.

2. *Chronic Lesions of the Biliary Tract*:

Under this heading are included the cases in which the history and objective findings cause the general surgeon to be doubtful as to the accuracy of his diagnosis and so he wishes to be sure that there is no pathology in the urinary tract which could account for the symptoms. One must always bear in mind that affections of the biliary and urinary tracts may co-exist. This is especially true of calculi. I have encountered such a combination in three cases.

The following diagnostic features must be kept in mind in differentiation of chronic biliary tract and renal conditions:

(a) The direction of the radiation of the pain. In biliary tract disease the pain may be of a dull aching character localized to the gall bladder region. More commonly, however, there is a history of recurrent attacks of more severe pain first referred to the same portion of the right upper quadant but radiating either to the right scapular region alone or to both scapular regions or towards the midline of the body.

In chronic renal conditions the pain is also of a dull persistent character, but referred to the corresponding iliocostal space. If the pain becomes more severe at times, it tends to remain localized to the iliocostal space and never radiates toward the shoulder but may radiate anteriorly. The type of colicky pain which is so common in ureteral lesions lower down is rarely seen in renal or upper ureteral conditions. One also seldom sees the reflex nausea and vomiting which is so common in biliary tract lesions.

(b) *Cholecystography and pyelography.* If there is a shadow which one suspects could be either biliary or a renal calculus, the task of excluding one of these is not a very difficult one for the urologist. We proceed first to secure a cholecystogram (B of Fig. 4) if the gall bladder retains the solution given by mouth or intravenously. We then take a flat plate to see whether the shadow is included in that of the gall bladder or remains external to it. Through a ureteral catheter the renal pelvis is next filled with the

usual pyelographic medium (a 12.5 per cent solution of sodium iodide is now almost universally employed for this purpose), and another exposure made to determine the relation of the resulting pyelogram to the suspected shadow. If it is included in the pyelogram, this is indicative of a renal calculus.

(c) The results of the urologic study (space will not permit a detailed description of this): Cystoscopy and ureteral catheterization supplemented by microscopic and bacteriologic examination of the separate urine as well as plain radiography and ureteropyelography, will yield within a comparatively short time sufficient information to exclude the kidney or ureter as the source of the symptoms or, on the other hand, enable the urologist to state that there is sufficient pathological change in the upper urinary tract to account for the clinical picture.

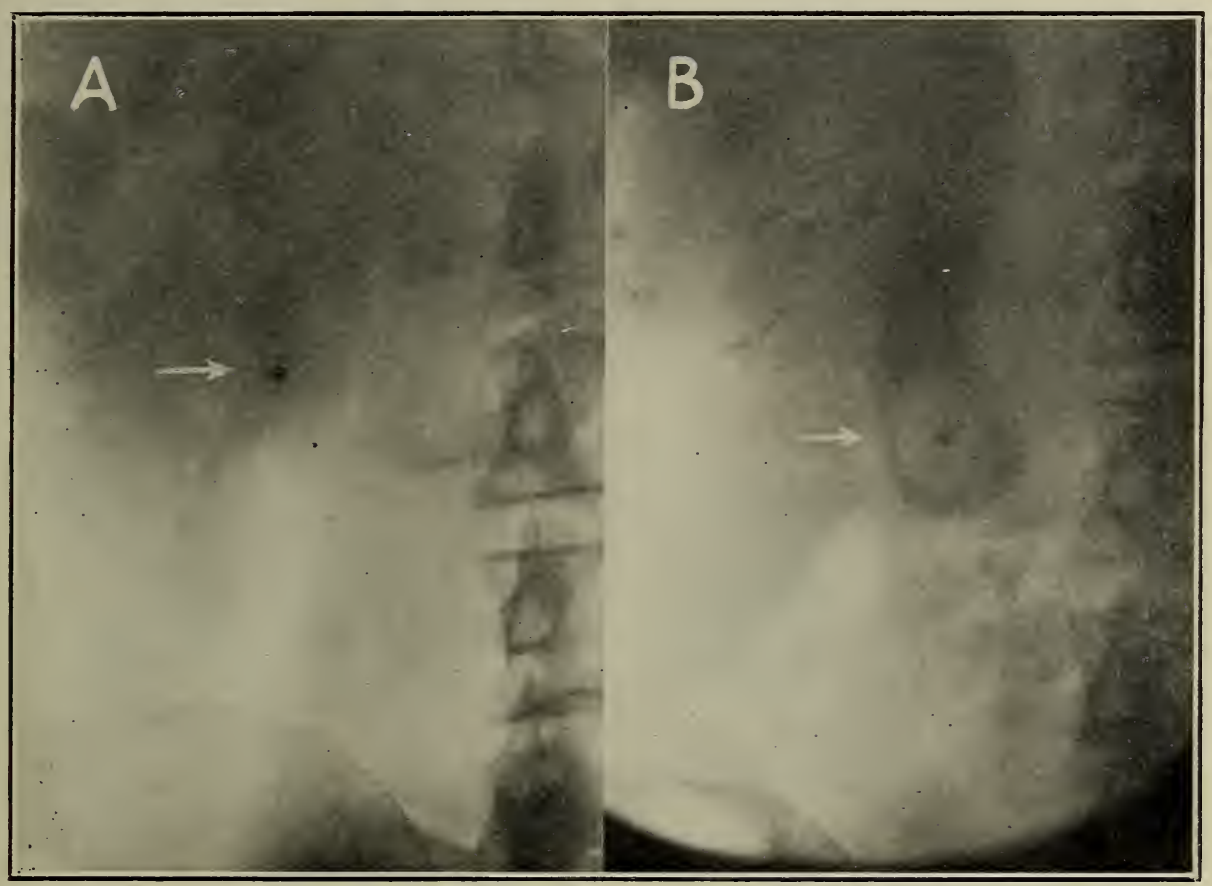


FIGURE 4.

Value of cholecystography in differential diagnosis of biliary and renal calculi. A. Arrow points to shadow lying over right kidney area. Dr. R. A. Arens suspected biliary origin of shadow. B. Cholecystogram of same case showing that above shadow was calcified center of a biliary calculus.

3. *Acute Appendicitis.*

This is a far more common source of error than is true of biliary tract lesions. If the appendix is in its most frequent location, the pain, rigidity and tenderness in the right lower quadrant presents no difficulty from a diagnostic point of view. If, however, the appendix is retrocecal and the pain, rigidity and tenderness are located higher and more posteriorly, i. e., in the iliocostal space (Fig. 2) the problem of differentiation of a retrocecal appendicitis with or without abscess from an acute renal infection without or with an accompanying perinephritic abscess is not only very difficult but at times almost impossible. No harm results in the latter group if ureteral catheterization and plain radiography yield no information, in making an incision through this iliocostal space, because it is the ideal place through which to drain a retrocecal appendiceal or a perinephritic abscess.

Our knowledge in regard to the causes of ureteral colicky pain has made much progress during the past ten years. Formerly it was taught that aside from migration of ureteral calculi, or kinking of the ureter by sudden ptosis of an abnormally mobile kidney, one could forget the other causes. We now recognize the fact that a number of additional causes (Fig. 5) can give rise to the clinical syndrome and in the absence of localized rigidity and tenderness, be easily confused with an attack of acute appendicitis. The chances for such a mistake in diagnosis will be evident when one recalls the fact that the syndrome or group of symptoms of ureteral colic resembles that of acute appendicitis in many re-

spects. The syndrome ureteral colic is composed of two chief elements; (a) those incident to the spasmodic contractions of the ureteral musculature and the resultant increased intraureteral and intra-renal tension, and (b) the so-called reflex phenomena due to irritation of the sympathetic

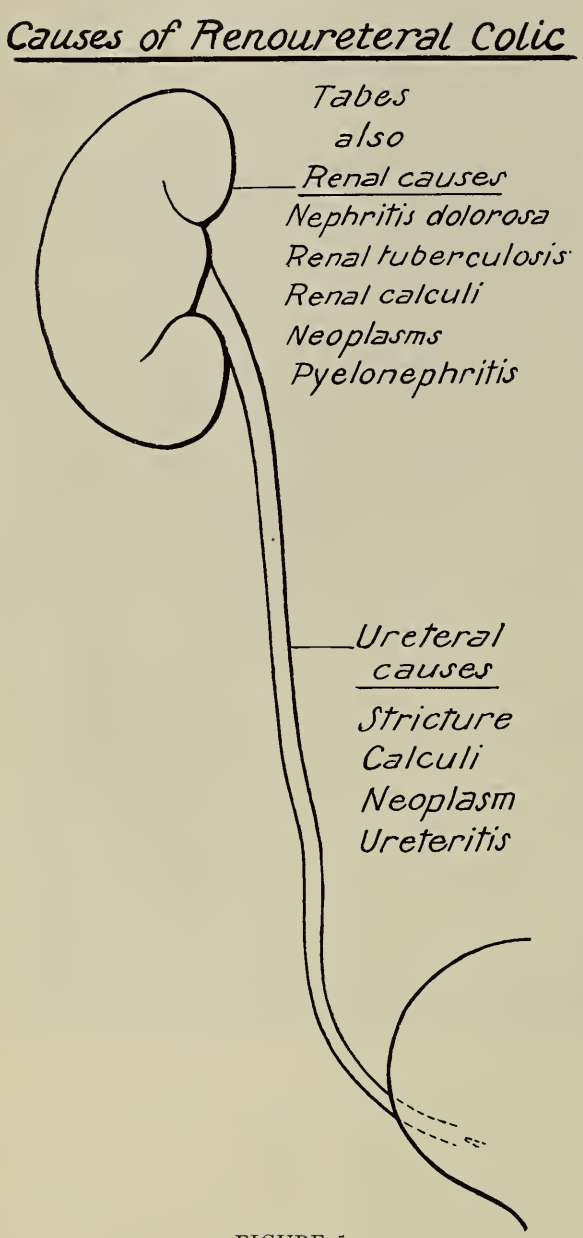


FIGURE 5.

Various causes of renoureteral colic. This illustrates the many conditions to be considered in the diagnosis of this syndrome.

nerve fibers so widely distributed to the peritoneum and abdominal viscera.

The pain is usually much more severe than is that of an acute appendicitis and radiates (Fig. 6) much more; e. g., downwards towards the testis or labia or less often, upwards in the direction of the kidney. The reflex symptoms are abdominal distention of moderate degree due to reflex inhibition of the motor apparatus of the intestines. In addition one observes reflex nausea, vomiting, rapid pulse, pallor and a condition resembling that of shock. The various conditions which can give rise to typical ureteral colics will be more fully discussed under chronic appendicitis. Suffice it to say here, that when a case presenting symptoms such as pain, nausea, vomiting, slight abdominal distention with gradual rise in temperature and leucocytosis is seen without localized rigidity and tenderness, one should stop to consider whether there could possibly be some trouble in the genito-urinary tract to account for such a clinical picture. The presence of red blood cells, either in microscopic quantity or a urine which is grossly (this term is frequently used now to express a hematuria which is visible on ordinary inspection of the urine) bloody, would, of course, make it possible that some such urologic condi-

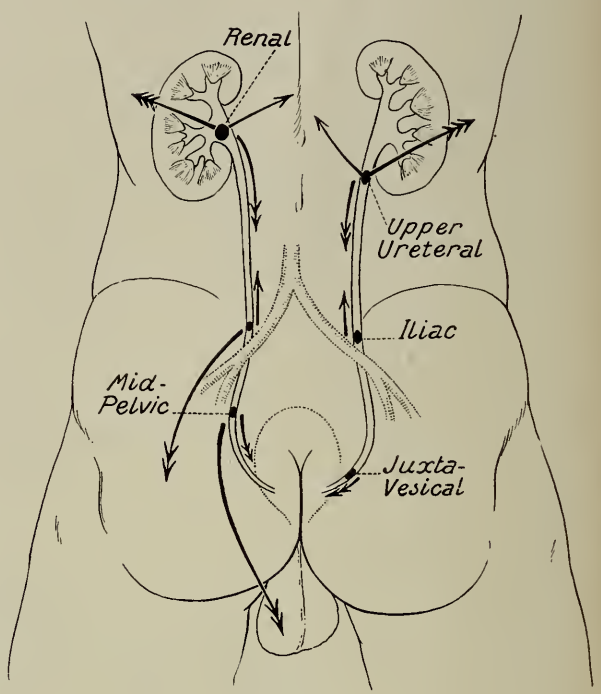


FIGURE 6.

Most common directions of radiation of pain in renal and ureteral calculi. The triple headed arrows indicate the most common, the double headed arrows the less common and the single headed arrows the least common direction of radiation.

tion is responsible for the symptoms. One must not forget, however, that hematuria both microscopic and gross may complicate an acute appendicitis. The term appendiceal hematuria is applied to such a condition. Cystoscopy and ureteral catheterization will often reveal that the bleeding is from the left kidney. This is explained by the presence of a glomerulonephritis of infective origin which is responsible for the hematuria accompanying an acute appendicitis. The proximity of the appendix to the ureter bears no etiological relation to the hematuria.

If one stops to question the patient as to the direction of radiation of pain and supplements this with a plain radiograph for suspected ureteral calculus (about 10 to 15 per cent of ureteral calculi fail to yield an x-ray shadow but can

often be diagnosed by encountering an obstruction on ureteral catheterization) and, if necessary, permits the introduction of a ureteral catheter if there is an absence of a shadow, it will be found not infrequently that the case is not one of acute appendicitis. As in the case of lesions of the biliary tract, there may be a ureteral calculus and a co-existing acute appendicitis although this combination is rare.

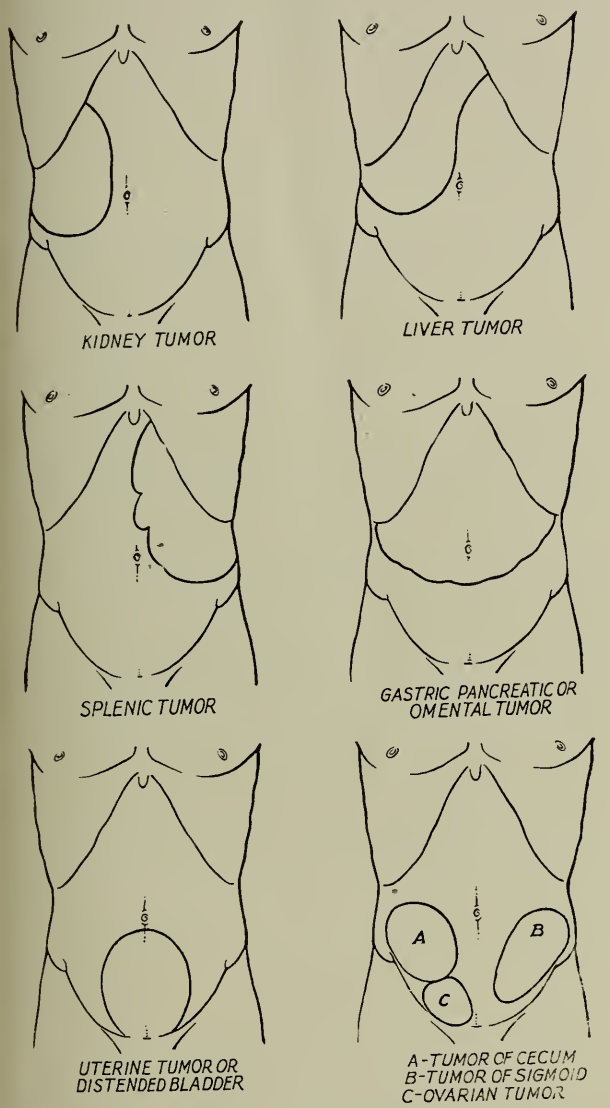


FIGURE 7.

Most frequent location of abdominal tumors when viscera from which they arise are normally placed.

4. *Chronic appendicitis.*

More errors occur under this heading than in the acute cases, because of the neglect of the diagnostician to consider urologic conditions giving rise to exactly the same symptoms. The recurrent attacks of fixed or radiating pain often with nausea and vomiting may just as readily be due to urologic conditions as to appendiceal changes. The various conditions (Fig. 5) for which the urologist must search for in such cases are the following:

1. Ureteral calcucli (usually in the iliac or pelvic portions.)

2. Ureteral strictures (at the same levels as above).

3. Ureteral kinks (due to abnormal renal mobility.)

4. Chronic nephritis of the painful type (nephritis dolorosa.)

5. Passage of uric acid or oxalate of calcium crystals in "showers".

6. Tabetic ureteral and renal crises.

7. Ureteritis (usually associated with pyelonephritis.)

8. Seminal vesiculitis with secondary involvement of the ureteral wall.

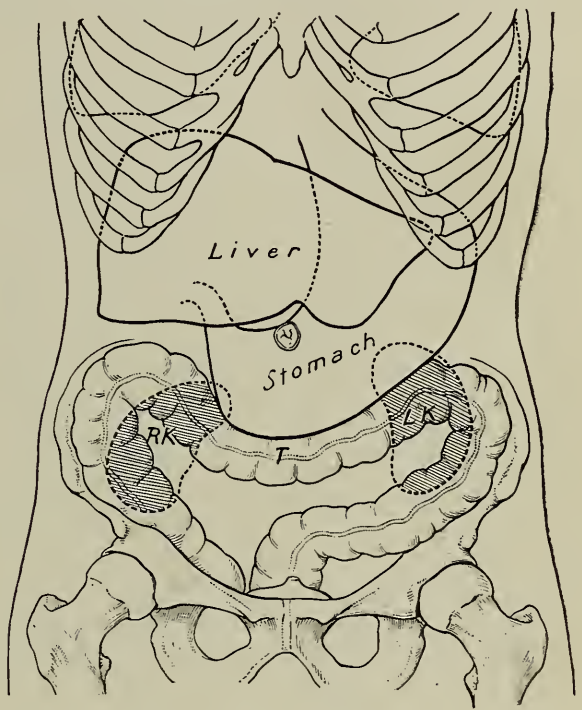


FIGURE 8.

Location of abdominal viscera (and of tumors arising therefrom) when generalized visceroptosis exists.

It is beyond the scope of this paper to give the details of how one eliminates these various causes of ureteral colic. The problem is not such a difficult one, however, and such a study can be completed usually within forty-eight hours. It will be conceded by all who have performed unsuccessful appendectomies that such a pre-operative examination could have been carried out easily as a part of the routine. If barium is to be given in order to study the gastro-intestinal tract, always permit the urologist to examine the patient first because the barium shadows may persist in the colon for two or three weeks and thus greatly interfere with the urologic study.

5. *Diagnosis of Abdominal Tumors*:

Before one attempts to determine whether a given enlargement is of intra or retroperitoneal origin, it is necessary to bear in mind the following:

The enlargement may have its origin in a normally located and developed viscus. (Fig. 7).

(b) The location may be at a different level from that of the normal structure either as a result of ptosis (Fig. 8) or as in the case of the kidney and cecum, failure to reach the final location, as the result of changes during embryonic life. (Fig. 9).

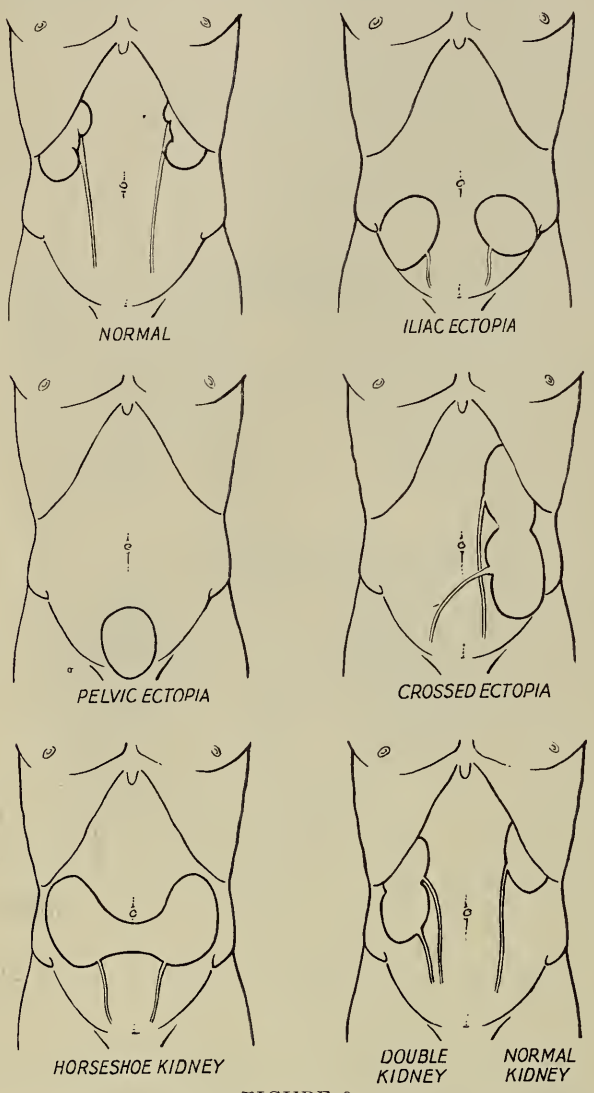


FIGURE 9.

Locations of normal kidneys as compared with those of anomalies of the kidneys and ureters.

(c) There may, as in the case of the kidney, be marked changes both in number and form of the organ.

Thanks to the routine employment of the opaque ureteral catheter and of ureteropyelography by the urologist in doubtful cases of abdominal enlargements, one can recognize the presence of a tumor of the kidney proper or of one arising from the structures immediately adjacent to it.

In cases of hydronephrosis giving rise to an abdominal enlargement, the enormously dilated renal pelvis, as seen in the pyelogram, is absolutely pathognomonic of this condition. Another diagnostic aid is to aspirate the contents of the renal pelvis and note how the tumor disappears. In cases of renal neoplasms the distortions of the renal pelvis, due to encroachment upon its lumen, gives rise to pyelographic deformities which are not easily mistaken for anything else. The only exceptions are large solitary cysts which develop usually at either the upper or lower poles of the kidney, can be felt as enlargements but do not encroach upon the renal pelvis sufficiently to cause a pyelographic deformity.

In cases of perirenal tumors such as retroperitoneal sarcoma, the displacement of the kidney and ureter as seen in the ureteropyelogram, is quite striking. In such cases the outlines of the renal pelvis remain nearly normal even though there is marked displacement.

WHY PHYSICAL THERAPY FAILS

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Physical therapy is the scientific application of such physical agencies as heat, water, light or massage, in the treatment of disease by the production of thermal, chemical and mechanical effects. All members of the medical profession are not agreed as to the value of each agency or each combination of agencies. We can safely say, however, that in the majority of cases physical therapy is not a success.

In the first place, wholly unwarranted and unscientific claims have been made by manufacturers of various types of equipment. Second, there is a lack of proper university training of both graduate and undergraduate medical men. Third, few truly clinical and scientific reports are to be found in medical literature. Fourth, there have been established too many so-called physio-therapy clinics by non-medical persons who have had barely sufficient training in this line of work to enable them to distinguish one piece of equipment from another. And fifth, there has been a widespread sale to quacks and charlatans of really standard equipment, with misuse thereof.

Shortly after the close of the World war our office desks began to be deluged with literature and our reception rooms filled with salesmen, eager to demonstrate a sure-fire, get-rich-quick scheme for treating our unfortunate victims. Many men right now have these machines in a corner of their office, covered with dust, and probably being used as bookracks. You ask them the reason for this and they answer, "It works all right in some cases, but not in all," or "When I put button X on point 3, as the instruction book says, Mr. Jones felt better immediately but it made Mrs. Smith much worse." Now why? Simply because this physician was practicing machine therapy, unmindful of the fact that individuals respond differently to physical therapy, just as they respond to drug therapy.

"The extravagant claims of some of the manufacturers as to the wonderful results to be attained, and especially the financial returns to physicians, have resulted in loading many a practitioner to the gun-whales financially, and as a result he has been tempted to treat every case with physical therapeutics whether such a treatment is indicated or not, thus violating the principal of not employing physical therapeutics in cases in which some standard procedure, less time-consuming and less expensive to the patient, would afford as good or better results."—(*Journal of A. M. A.*, Vol. 89, No. 15, Oct. 8, 1927; F. B. Granger.)

Following the extensive sales campaign came the system of instruction courses sponsored by manufacturers. The idea back of this step is fundamentally proper, but each manufacturer was demonstrating his own equipment, and the methods outlined were, as a rule, applicable only to that particular apparatus. This practice can not be totally condemned, for, while a few courses were rank with commercialism, yet quite a number were well conducted and very much worth while, and acquainted the students with the fact that there is more to the practice of physical therapy than pushing a button.

How, then, are we to learn the value of these measures and their proper application? There can be but one answer—the medical school undergraduate and postgraduate courses. At present very few medical schools in the country offer a satisfactory course in physical therapy. In most cases, a course is sandwiched into one of the last two semesters, occupying only one or two hours a week. This is taught oft times by the professor of therapeutics, and he mentions something about Galvani's experiment with frog-legs, gives a few fancies about diathermy, and names the steamer rates to the famous spas in Europe. Or, if the course is taught by one who really knows the subject of which he speaks, as in our own State University, the time is so short that in the effort to cover the entire field he is compelled to touch but lightly on each phase; with the result in either case, that the student remembers just enough about the course to recall a few choice phrases or terms. This same professor of therapeutics would not permit one of his students to gave a dose of morphine to a patient who advises him over the 'phone that she is ill, without first finding out the nature of her complaint and ascertaining whether she needs morphine or ipecac. He would not give his office girl a set of surgical instruments and send her to the hospital to perform a cholecystectomy; yet he would ask her to give a patient a diathermy treatment according to the book of instructions which accompanies his new machine. In each instance the procedure is equally fallacious.

Our training in surgery and drug therapy begins in the premedical work. Since physical therapy is one of a group of medicine, surgery and physical therapy, it should have an equal share in preparation. We should have pre-medical instruction in medical physics, laboratory training in electro-physiologic reactions, and actual clinical bedside experience, along with a course of lectures by one trained in this field of work. This ideal is not practical now, however, for our medical curriculum is already overloaded with too many non-medical and non-essential subjects. But, if we recognize physical therapy as of equal value with medicine and surgery, then we must give it more attention in our teaching institutions. Opportunity should be afforded post-graduate students to obtain special training in our medical schools through the didactic and clinical channels used in the other specialties.

A few years ago it was unusual to pick up a medical magazine in which any reference was made to physical agencies in the treatment of disease, while now it is a rare thing to pick up a magazine in which we do not find reference to physical therapy. Such men as Hess, of New York, Lawrason Brown, of Saranac Lake, Granger, of Boston, and Coulter, of Chicago, have made truly scientific contributions to the literature. It is essential that those of us who are practicing physical therapy should report on our work frequently, presenting our cases in a clear unbiased light. And we should not report our successes alone, for out of failure comes our greatest good. It is as important to know when not to do a thing as it is to know when to do it.

The Council on Physical Therapy organized by the American Medical Association after the plan of the Council on Pharmacy and Chemistry, is publishing authoritative articles in this field in an effort to correct many misunderstandings and misrepresentations in the medical world. They express themselves in this wise: "The Council on Physical Therapy will endeavor to point out to the medical profession the advantages and disadvantages of physical therapeutics so that its abuse may be reduced to a minimum and its scientific possibilities may be appreciated."

The widespread demand for physical therapy in the World war led to the training of non-medical individuals in the technical operation of various types of equipment. This was entirely necessary then, and it is necessary now to have a technician in the office or hospital who can take care of the work under the direction of a medical mind. But it is certainly wrong to permit the establishment of physico-therapeutic clinics by technicians who are not trained medically as well as technically. The most atrocious idea which has come to our knowledge recently is the fact that some of our Y. M. C. A. and Y. W. C. A. organizations have equipped their gymnastic rooms with physical

therapy apparatus and are using the same for treatment purposes.

To quote again from the reports of the Council, "The treatment of disease, whether by drugs, surgery or physical agents, belongs solely in the realm of medicine. A physician would not refer a patient to a non-medically trained person for treatment by either drugs or surgery; yet many physicians may refer patients to technicians, masseurs, gymnasts or nurses who have received training in physical therapeutics, or even to members of the various cults, for physical therapeutic treatment. Therefore, physical therapeutics must be recognized as a component part of medicine, and patients requiring this type of treatment should be referred only to a physician trained in this specialty."

The rapid ascendency of chiropractic and other systems of drugless healing was largely due to their spectacular nature. It was perfectly natural for them to add a few "electrical treatments" to an already weakening repertoire, among them the "Vita-Net blanket", the "magnetic coil", and "violet ray", all excellent money extractors. Our council is hard at work formulating regulations which will govern the sale to and the use of this equipment by physicians only, or under the advice of physicians. A noteworthy step in this direction is the placing of Ultra-Violet generators in private homes only under the guidance of the attending physician.

A discussion of this subject would not be complete without offering some idea of how we can change our present failure to success. In the first place, let us be true to our oath of Hippocrates; let us treat our patients conscientiously and humanely, and not merely as a source of income. We must depend on the salesmen only to the point of explaining the mechanical features of his product. We should avail ourselves of a post-graduate course somewhere, and attend the conventions of physical therapy associations.

The practice of physical therapy-medicine by technicians should be discouraged by referring cases only to physicians skilled in the work, just as surgical patients are referred to men skilled in surgery.

Physical therapy is one of the greatest assets to modern medicine, but it should be used only as an adjunct—as one of the triad—medicine, surgery and physical therapy. It should be employed only after careful study to obtain the proper physiologic effects in a given pathologic condition, and never in place of other methods which have proved superior.

SPECIAL ARTICLE

DECORATIVE REFORM IN THE PHYSICIAN'S OFFICE

By Gladys Craig of
L. S. Ayres & Co.
INDIANAPOLIS

A tour of some of the offices of Indianapolis physicians by a representative of L. S. Ayres & Company has revealed some interesting examples of good interior decorating. It has also revealed some uninteresting examples of bad decorating. Doctors who have given some thought to this matter may have a message for those who have not. We will therefore set down some of their statements about office decorating, together with our own observations and suggestions.

"The more comfortable you make the patient before you get to him, the more intelligent the history you get," said one physician who has risen high in his profession as a general practitioner. He has succeeded in creating a livable, homelike atmosphere in his office, and he receives his patient in the spirit of a visitor, and not as "just another case." His consultation room is like a small luxurious private library with open book shelves, deep chairs, a few pictures and a mirror. Upon entering the room the first thing that meets the eye is an old-fashioned what-not full of trinkets which the doctor has brought home from his various trips to Europe. No one can pass that what-not without stopping to exclaim and inquire into the history of some of the objects. The most popular interest attaches to an English whiskey bottle more than a hundred years old. What with pewter plates to look at, gargoyles, and pieces of shrapnel, it is difficult to remember the ache of one's tummy.

"This is my 'piece de resistance' ", said the doctor, and switched on an electric light which illuminated a striking bird made of varicolored beads, a piece which he himself had bought in Venice. Such simple contrivances serve to divert the patient and put him into a mood receptive to the doctor's advice.

Before he knows it he is comfortably seated with his back to the laboratory door, and is launched upon the story of his past life. Another office visited was famous for its oil paintings and oriental rugs. One rug, the doctor said, had been presented to the house of Henry Clay by the Sultan of Turkey. He liked to tell its history and how he came to acquire it. "Oriental rugs are much more interesting than domestic," he said "and though they are more expensive, they admit of much rougher usage." The walls of his consultation room were lined with a series of mural panels done in oil, depicting the whole history of medicine. Romans, Moors, Egyptians and Greeks were represented, and each panel carried its story.

In the time of Babylon the sick repaired to the public highway where it was their privilege to discuss their symptoms with the passersby. This interesting bit from the lore of the past was the subject of one of his paintings.

It is obvious that the doctor could not take time to explain these things in detail to every patient. The significant thing is that these men brought into their offices things which pertain to the life they both lead, which tends to remove sterility and replace it with individuality and charm.

"We are getting away from the pill in here," said one doctor, "and bottles of glorified liquor. Once we were proud of our monsters which we kept pickled in alcohol. Now we have outgrown this method of 'interior desecration.' We have changed our office from a chamber of horrors, and made it an adjunct of the home."

The doctor's profession, perhaps more than any other, is one of continuous student activity, and therefore carries with it a tendency to cultural hobbies. Books, etchings and prints found in the office of the physician are indicative of his tastes and what he does with his leisure hours. One doctor whose hobby is photography had some of his prize winning pictures just above his desk. Another found that patients who had traveled were always attracted by pictures of the scenes they had visited. One of the most interesting things to be found in the city was a whole side wall filled with signed photographs of literary and military notables who were personal friends of the physician who owned them. None but the blind could pass this wall without having their interest aroused.

One group of offices outstanding for quiet taste and beauty has walls panelled in walnut. In the outer room the secretary's desk is of period design. In one of the consultation rooms the flat topped desk is delightfully outfitted in brass. Exquisite electrical fixtures, lamps, comfortable chairs and couch complete a study worthy of the most fastidious home. These doctors affirmed that they had tried to provide an atmosphere in keeping with the class of people with whom they had to deal. Besides, they confessed, they liked such comforts for themselves. Much of their time was spent in their offices. Therefore, why not make them equally as beautiful as home? Each doctor visited had some humorous reference to make to the customs of the past. "I hope you notice," said one of these, "that we do not have a picture of a doctor seated at the bedside of a sick child."

Doctors who admire the Italian influence in decoration will be interested in the effect achieved by a local physician. When the Medical Arts building was in the process of construction he engaged a suite for his office and had it decorated in the Italian manner. The walls are plastered in a deep cream color, with large blocks marked on the surface. The floor is some stone composition. The bare walls give a feeling of restraint and restfulness, and the few well chosen pieces of furniture are of dark wood upholstered in a warm rose. The austerity of the room is offset by the deep coloring of the fabrics.

We have so far mentioned only the offices outstanding for their taste and beauty. We are sorry to confess that the vast majority have not troubled themselves over the matter of office decoration, and it is in the hope of stimulating their interest that the foregoing offices have been described. In the June issue of "Medical Economics" there is an interesting article on "What Patients Think of Their Doctor's Offices." The outstanding complaints, which the physician seldom hears, were cited as follows:

"I don't like to look at surgical instruments."

"I hate gloom."

"Why don't they blow away the odor of medicines?"

"Waiting in a roomful of sick people makes me sick too."

"Doctors' offices are always chilly."

In a previous article we have suggested that all surgical instruments be kept in a small adjoining laboratory. If space prohibits this, we suggest a cabinet with wood doors to replace the white enamel and glass structures which detract from so many offices. Nothing is more chilling to the patient's blood than an array of scissors in plain view. A nervous person will visualize himself bleeding to death with every artery cut,—a state of mind which makes him difficult to handle. From a mere aesthetic viewpoint, a good wall cabinet is more beautiful to look at than a glass case, and certainly brown can be kept just as clean as white.

As for the gloom and the chilly atmosphere, nothing will take the place of sunlight and a good heating plant. Yet if the condition is not so bad, much can be done to dispel a gloomy atmosphere by the clever use of color. In the offices which we visited many of the waiting rooms had no outside windows and were therefore dependent upon artificial lighting. In order to get the best out of this method of illumination, place the lights so that the daylight is not only replaced by a pleasant, subdued general illumination, but supplemented by direct lights on the table and by the chairs for reading. Light warm colors such as cream and yellow, will do much to dispel an effect of chill and gloom. Yellow, rose and orange give warmth to a cold or dark room just as green, blue and gray cool an overbright one. Even if the waiting room has an outside window, the choice of color should depend upon the exposure. A room with windows to the north may have light, but it is a cold light, and calls for colors of yellow and red. Sunlight can never be imitated, but it can be suggested by the use of yellow gauze curtains. The light shining through them gives an illusory glow.

In rooms of southeast or southwest exposure, colder tones must be used, and the background may be darker since the sun provides all the yellow necessary for the color scheme. It should also be remembered that light colors make a room look larger, whereas dark colors tend to contract its size.

So much for dispelling gloom by the use of color. There remains two complaints in our list of criticisms from patients. The doctor himself will know more about how to blow away the odor of medicine than we know. And we have no suggestions to offer concerning the bad psychological effect of waiting for the doctor in company with other sick people, other than that if they are all made comfortable, they are less apt to have a morbid curiosity about each other. One patient, quoted in the same article from *"Medical Economics"* after describing the way he takes on other people's illnesses by suggestion, says: "Personally, if I were a physician I'd have individual waiting rooms for single persons or for families. I wouldn't let one patient see all the other sick and ailing people who come to call on me. Instead I'd try to make each individual patient just as happy and comfortable as possible while waiting." We think that perhaps this is a large order, though in our rounds we did run into a physician, a child specialist, who had three rooms in addition to his general waiting room. He went from room to room in order not to lose time while the mother was redressing her child. And as he works by appointment, it is doubtful that many sick children are obliged to wait in the same room.

One final criticism of waiting rooms comes to our mind as a result of our study of offices. The waiting rooms are usually long and narrow, and they lack a center of interest. A davenport set at right angles with the wall, with a strip of tapestry on the wall at the end, to lend heighth, is one suggestion for handling this problem. A drop lamp and a small table should complete the group. Another scheme is to place one high piece of furniture in the center of a wall space, a cabinet, perhaps, or a tier of open book shelves, and use two pictures of corresponding size on each side of it. A room with a long stretch of wall with nothing but chairs before it is a deadly thing. In furnishing an office never forget the decorative value of an interesting wall piece of tapestry or some printed fabric. The India prints, for instance, which are very colorful are also inexpensive. Those in Paisley patterns have so many soft colors that they fit into almost any color scheme.

The chair, of course, is by far the most important part of the equipment of any office, and the regulation office chair is certainly an abomination. Comfortable chairs, attractive in design, and upholstered in fine fabric, are a compliment to the patient and invite him to relax and forget his ills. One of the trade magazines devoted to office equipment, has recently run an article called "The Creative Selling of the Office Chair," and this indicates that the manufacturer, at least, takes his chair seriously.

With so many sources of information available, and with the help of the deferred payment plan, it should not be impossible for any physician to go in for decorative reform in his office. Many physicians have been helped to redecorate their offices without large expenditure. In one instance where the doctor preferred the new furnishings for his house, the discarded pieces were rejuvenated for office use, and an excellent effect was achieved. In expert hands paint and ingenuity often go farther than a large and elaborate investment.

ORGANIZED MEDICINE AND INDIVIDUAL HEALTH AND MEDICAL GUIDANCE

The public is willing to accept and indeed actively desires protection against quackery and fraud. The public seeks direction to safe and helpful medical and health services and facilities. Thousands want this guidance and know that they need it. Thousands raise such questions with numerous agencies by correspondence and are wisely though very inadequately in the great majority of cases told to "See the Doctor." The answer is not enough. DONALD B. ARMSTRONG, New York (*Journal A. M. A.*, Sept. 1, 1928, says that the problem can never be handled on a national basis or by correspondence. What is vitally needed is a local information service and a medical guidance bureau to which persons may be advised to turn for impartial, unprejudiced, scientific and sympathetic personal guidance. If this service is to be given locally, should it be the work of the health department, of voluntary agencies or of local medical societies? Perhaps all need to participate, but in Armstrong's opinion it would appear essentially to be the obligation of the local organized medical unit, for it involves in a sense rationally and intelligently putting its own house in order. Medical organizations seem to be faced with three possibilities, a choice accentuated by the public demand for guidance: Definite state control, with a more or less compulsory degree of public service in this field. Semipublic provision through salaried medical service by means of semipublic pay or free clinic facilities. The incorporation of health and medical guidance into the routine practice of medicine, under the auspices of private medical organizations. The accomplishment of this service must be approached along three principal lines: 1. It is necessary to get physicians in increasing numbers ready to practice private preventive medicine and teach personal hygiene. This medical educational work is an obligation which rests primarily on medical schools, medical societies and similar professional organizations. 2. It is important to have the public more fully aware of its needs in this field, and of the competence and willingness of orthodox medicine to meet those needs about which it is already conscious. 3. It is necessary to establish a local machinery which will purposefully and usefully associate service with need. Such a bureau would be made known to the public through dignified publicity. It would arrange for individuals to see competent physicians. It would keep patients out of the hands of quacks and frauds. It would facilitate a wise choice of medical counsel from approved lists of physicians or specialists endorsed by the county society on a functional and geographic basis. The service must be more than a gesture, more than purely informational—it must be real personal guidance.

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Devoted to the Interests of the Medical Profession of Indiana
Albert E. Bulson, B.S., M.D., F.A.C.S.
Editor and Manager

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EDITORIALS

THE GARY SESSION

Seldom, if ever, in the long history of the Indiana State Medical Association has so much activity been crowded into three short days as during the seventy-ninth annual session of the organization held at Gary September 26th, 27th and 28th. Judged from every angle the session was a success. The scientific meetings were all well attended; the scientific program was interesting and instructive; the business meetings of the Council and House of Delegates were speedily and efficiently handled; and the entertainment was excellent.

It was the entertainment feature that the representatives of the Lake County Medical Society stressed when they invited the Association to come to Gary, and each and every member of the local medical society more than made good the promise of a whirlwind, rapid-fire time. In fact so rapid was the action, and so many varied features were on the program, that the only complaint that could be made was that the Lake County hosts and hostesses allowed too short a time between parties, scientific meetings, and sightseeing trips for the 584 physicians, their wives and guests, numbering 308 (total registration 892), who attended the session to get their breath—or their meals.

Activities started unusually early Wednesday, the first day of the session, everything being arranged so that everyone, including the golfers, the councilors, and the members of the House of Delegates, could take the much-talked-of steel mill trip, which started at 1:30 in the afternoon and ended shortly before 5 o'clock. Nine carloads of physicians on flat cars especially arranged for sightseeing made the tour of the Illinois Steel Company mills under the special supervision of W. P. Gleason, general superintendent. Each car was provided with employees of the company who acted as guides, so that every physician who made the trip came away with a comprehensive understanding of the manufacture of steel from the time that the iron ore is unloaded from the lake freighters, is formed into blazing hot ingots, is rolled out like giant sticks of molten spaghetti and cut up into steel rails, or shaped into Pullman car wheels.

Making as quick a costume change as a vaudeville performer, each physician scarcely had time to get the soot of the steel mills off his face and into a clean shirt and on hand for the big smoker and entertainment Wednesday night. Set in the ballroom of the new Hotel Gary, where convention headquarters were located, the buffet supper, along with Benson's orchestra and entertainers, was very entertaining. The master of ceremonies was E. M. Shanklin, M.D., of Hammond, chairman of the Arrangements Committee, who introduced in turn the singers, the dancers, the girl principals in a two-round boxing contest, and a score of Lake County physicians who put on a snappy song and dance act. All in all it was as entertaining and enjoyable a fun fest as the Association ever has had at its annual occasion.

As usual, one of the features of the smoker was the presentation of the golf prizes, Dr. Robert F. Wilcox, of Laporte, winning the golf championship for 1928 over a field of almost one hundred competitors who took part in the tournament during the morning at the Gary Country Club.

Thursday and Friday were devoted to scientific meetings, and as there were no section meetings the entire time was given over to papers and discussions of topics interesting to the general practitioner.

The annual banquet was held Thursday evening. Dr. William Allen Pusey, Chicago, past president of the American Medical Association, was the speaker of the evening, his subject being "The Worldly Rewards of Medicine." The presentation of certificates of merit to eleven living past presidents of the State Association who were present at the session was the unique and altogether fitting feature of the banquet, and perhaps of the entire session. Dr. Thomas W. Oberlin, of Hammond, acting as toastmaster, introduced Dr. Albert E. Bulson, of Fort Wayne, editor of The Journal, who made the presentation speech and distributed the certificates of merit. The past presidents who were on hand to receive the certificates are Dr. Charles S. Bond, Richmond, 1894; Dr. Miles F. Porter, Fort Wayne, 1895; Dr. William N. Wishard, Indianapolis, 1897; Dr. John C. Sexton, Rushville, 1898; Dr. John B. Berteling, South Bend, 1902; Dr. Charles H. McCully, Logansport, 1919; Dr. David Ross, Indianapolis, 1920; Dr. William R. Davidson, Evansville, 1921; Dr. Charles H. Good, Huntington, 1922; Dr. E. M. Shanklin, Hammond, 1924, and Dr. Charles N. Combs, Terre Haute, 1925. Those past presidents who are living but did not attend the banquet, and for whom certificates have been prepared, are Dr. George F. Beasley, Lafayette, 1892; Dr. George W. McCaskey, Fort Wayne, 1900; Dr. George T. McCoy, Columbus, 1904; Dr. William F. Howat, Hammond, 1911; Dr. Joseph R. Eastman, Indianapolis, 1917; Dr. William H. Stemm, North Vernon, 1918; Dr. Samuel E. Earp, Indianapolis, 1923, and Dr. Frank W. Cregor, Indianapolis, 1926.

One of the reasons for the success of the session was the delightful program of entertainment for the ladies, arranged by the wives of the Lake

County physicians. In addition to this program the women physicians had a banquet of their own which was addressed by Dr. Mary McKibben Harper, of Chicago, secretary of the National Association of Women Physicians.

Some sixty county medical society secretaries attended a breakfast and made plans for the annual county medical society secretaries' meeting at Indianapolis next spring, and informally discussed problems that arise in county medical society organization work.

The revival of the scientific exhibit at the annual state session caused much favorable comment. The idea of having these exhibits in connection with the yearly sessions originated in Indiana, and was first carried out at the American Medical Association convention under the direction of the late Dr. Frank B. Wynn, of Indianapolis. It is to be hoped that these exhibits will be continued and enlarged at future sessions. Through the courtesy of the Gary Commercial Club, whose beautifully furnished rooms were open to all visitors during the session, the scientific exhibit was housed in the club quarters.

Dr. Angus C. McDonald, of Warsaw, was elected president-elect for 1930 at the Friday morning meeting of the House of Delegates. He will take the place now occupied by Dr. Charles E. Gillespie, of Seymour, who in turn will succeed Dr. George R. Daniels, of Marion, whose term as president of the Association expires on January 1. For the third successive time Dr. William A. Doeppers, of Indianapolis, was re-elected treasurer, and Dr. Harry Elliott, of Brazil, and Dr. David Ross, of Indianapolis, were elected delegates to the American Medical Association sessions for the next two years. Dr. Frank S. Crockett, of Lafayette, and Dr. Robert M. Moore, of Indianapolis, were selected as alternates. The House ratified the selection of Dr. Bayard G. Keeney, of Shelbyville, as councilor for the Sixth District, and Dr. F. S. Crockett, of Lafayette, as councilor for the Ninth District.

Due to the press of personal business Dr. William R. Davidson, of Evansville, who has served as chairman of the Council for a number of years, resigned his position as councilor and as chairman of the Council. He will be succeeded as councilor for the First District by Dr. John H. Hare, of Evansville. Dr. E. E. Evans, of Gary, was chosen temporary chairman of the Council to serve until January 1, 1929, when a permanent chairman will be elected.

The Women's Auxiliary chose the following officers: Mrs. W. R. Davidson, of Evansville, to succeed Mrs. F. W. Cregor, of Indianapolis, as president; Mrs. M. A. Austin, of Anderson, president-elect for 1930; Mrs. Edgar Kiser, of Indianapolis, secretary, and Mrs. Everett Zaring, Terre Haute, treasurer.

Evansville was selected for the convention city in 1929 by unanimous vote.

DIPHTHERIA PREVENTION

To be perfectly frank we have felt just a little ashamed of the medical profession of Indiana for its apathy concerning diphtheria prevention, for while we recognize that in some communities the health officers, school physicians, and private practitioners of medicine have accomplished much in immunizing practically all of the children of the community, yet there are many cities and towns in Indiana where the subject has not received the serious attention that it deserves. We have been talking about this matter in The Journal, and the State Board of Health through its bulletins and circulars has been urging the adoption of preventive measures, so that any lethargy on the part of physicians cannot be attributed to lack of information.

We now urge every reader of The Journal to enlist his services in a campaign of diphtheria prevention. Do not procrastinate—do it now. Diphtheria can be eliminated from the state if the regular medical profession will put its shoulder to the wheel and bring about immunization of every school child. The weapon which has proved powerful and effective in the battle against diphtheria is toxin antitoxin, which enables us to immunize and protect all susceptible persons. The control of the disease is in the hands of the physicians, and it is a duty we owe ourselves as well as the public to not delay in adopting a measure that has proven of value. The method is simple, easily applied, and without danger. It consists in the administration of toxin antitoxin which in reality is a mixture of a diphtheria toxin and a diphtheria antitoxin. The composition is such that the toxin present produces no harmful effects on the body and yet it is effective in producing immunity to the disease.

To quote from one of the health board circulars, toxin antitoxin is a clear, transparent fluid. A good preparation is never cloudy. The mixture is stable for at least six months, and during that time does not deteriorate if kept in a cool place. It has been found that the amount sufficient to produce immunity is three doses of one ccm. each, given at intervals, using a standard preparation. The same dose of one ccm. is given at each injection for all ages. Three injections are absolutely necessary, and the intervals between injections should be not less than seven nor more than fifteen days. The simplest procedure is to have the patient report on the same day of the week for three consecutive weeks. The injection is given like an ordinary hypodermic, with the skin prepared as for an ordinary hypodermic, which may be given in the deltoid region of the arm, or the upper gluteal region, and preferably subcutaneously. In many cases there are no reactions, either local or general. In susceptibles, a local reaction characterized by redness, a certain degree of tenderness, and a little swelling may appear at the site of injection. This reaches its height in two or three days and gradually sub-

sides. General reactions rarely occur in young children. In older children malaise and slight fever may be seen. Permanent harmful effects are never observed after the use of toxin antitoxin. The immunity begins to develop a few weeks after the third injection, but requires from three to six months to reach its height in all immunized persons. Immunity has been shown to last in the great majority for ten years, and in all probability remains for life.

In children over ten years of age one may do a Schick test and then give toxin antitoxin to all those found to be susceptible. Irrespective of the history of previous immunization, or clinical diphtheria, a positive Schick test indicates the individual need for toxin antitoxin. Up to six months of age eighty per cent of infants are immune. This immunity is conferred upon the child by the mother. From nine months to three years practically all children are susceptible. From three to ten years about half of all children are susceptible. Every child should be immunized. From ten to fifteen years less than one-quarter of the children are susceptible. For this age group it is advisable to give the Schick test to determine the susceptibility, but toxin antitoxin may be given without a Schick test. One can determine whether the toxin antitoxin injections have conferred immunity on the children by making a Schick test five or six months later. In any case where a suspicion of diphtheria exists, antitoxin should be given.

With the beginning of school the opportunity is presented to carry on an educational campaign by the health and education authorities. Even greater opportunity is presented the medical profession. Every physician can with propriety inquire whether or no the children of the family have been immunized. Every child should be immunized if we are to eliminate diphtheria, and every physician should not only advocate but practice diphtheria immunization.

We hope that Indiana will be in the vanguard of those states that have eliminated diphtheria from their borders. To the individual physicians of the state belongs the task of spreading the gospel and carrying on the work. Let's go!

RELATION OF THE INDIANA UNIVERSITY SCHOOL OF MEDICINE TO THE STATE OF INDIANA

The relation of the Indiana University School of Medicine to the state is most intimate, important, and vital.

The average life rate in the United States today is forty years. The average life rate in the state of Indiana is forty-two years. These two years above the average life rate for the United States are given the people of Indiana by the medical profession of the state, about eighty per cent of whom are Indiana graduates. The quality of the graduates of the Indiana University School of Medicine has, therefore, a direct bearing on length of life, health, and earning capacity of every family, and finally upon the happiness, prosperity, and general welfare of families and communities of the entire state. That the average life rate in Indiana is two years beyond that of the United States is an indication of the fact that the Indiana University School of Medicine, now twenty-five years old, has been performing its function in a splendid way.

We are now confronted with new situations which will endanger our splendid service, unless local changes are made, meeting adequately these new conditions. These new conditions are:

First. Enormously increased expenditures for medical education throughout the United States. The five million dollar medical plant has become common, and plants costing ten to twenty million are in operation or are being built. One medical school plant is under construction at the present time calling for an outlay of sixty million dollars.

Second. The second new condition is an enormous increase in number of applications for matriculation in the freshman year of schools of medicine. Our own experience is typical. We matriculated forty-three students in the freshman class of our school of medicine in 1918. The number grew rapidly until we enrolled in excess of one hundred, our maximum capacity, in 1922. In 1925 we had many more applications than we could care for. In 1926 there were 350 applications for freshman medical matriculation. In 1927 there were 460, and this year, 1928, the number is in excess of 700, more than twice as many as two years ago, and seven times as many as our small building and limited quarters will accommodate. This increase in freshman enrollment has gradually affected all classes of the medical school. In 1918 there was a total enrollment of 208; last year our total enrollment was 422, more than double in nine years. Each year now we are forced to turn away many students who, but a few years ago, would have been considered adequately prepared.

Third. A third consideration is that there has been a decrease of fifteen percent in the number of doctors of medicine in Indiana since 1914, and twenty-five percent of the doctors we have are sixty-five years of age, or over.

Now what is necessary to meet these unprecedented conditions?

1. At Indianapolis the building program so splendidly begun must be continued. A broad vision for the future has provided a site unique in size among medical schools. Friendly cooperation of the city of Indianapolis surrounds this fifty-acre medical site with 125 acres to be parked in due time. The generosity of friends has provided the Long, the Riley, and the Coleman Hospitals, and the Ball Nurses' Home, unexcelled anywhere in the world.

2. At Bloomington, however, the medical school occupies Owen Hall, one of the first buildings

constructed on the present university site. It was adequate from 1911 to 1918 for classes of twenty-two to forty-five, at a time when the present building program had not as yet begun, and present enrollments were wholly unanticipated. Today it is pitifully inadequate, both for students and faculty, and necessitates our refusing the matriculation of an increasing number of men for whom there is increasing need in our state. The present staff is so burdened with instruction that time and energy for investigative work, a function of every medical school, is distressingly small. The teaching staff should be doubled to care for a doubled enrollment, but there is no room in Owen Hall to house an increased staff.

Relief of this situation is a first demand upon the new building budget of the University, and a greatly increased budget for increased maintenance and increased staff is one of the most urgent of the school's needs, both at Bloomington and Indianapolis, for which the coming legislature should provide liberally. B. D. MYERS, M.D.

EVALUATING PROPRIETARY MEDICINAL PREPARATIONS

Judging from the number of circulars received by us through the mail we are led to believe that there are many manufacturers of proprietary medicinal preparations of secret formula. Evidently they find plenty of "suckers" among medical men who are willing to experiment on their patients with preparations that have nothing more to commend them than the statements of pharmaceutical manufacturers not a few of whom are misguided, some are tricky, and a limited number are downright dishonest. Why a physician should be a dupe of the manufacturers of proprietary medicinal preparations in this day and age is hard to understand. There was a time when physicians had to depend very largely upon their individual resources in evaluating proprietary medicinal preparations, and altogether too often the confiding physician found that he had been victimized when he believed the glib tongue of the detail man or the propaganda contained in circulars or other advertising coming through the mails. That time has passed, for it is now nearly thirty years since the American Medical Association established its Council on Pharmacy and Chemistry for the purpose of determining the ingredients, quality, therapeutic value, and honesty with which proprietary medicinal preparations are sold to physicians or public. In other words, the council was established for the distinct purpose of protecting the medical profession and the public against fraud, undesirable secrecy, and objectionable advertising in connection with proprietary medicinal articles. Those physicians who wish to profit by this protection can do so by confining themselves in their prescribing to the articles which are contained in the U. S. Pharmacopeia, the National Formulary, or the New and Nonofficial Remedies published by the American Medical Association. The latter contains descriptions of such proprietary articles as have not been found to conflict with the rules of the council, and such simple nonproprietary and nonofficial substances as seem of sufficient importance.

Among some of the rules governing admission of proprietary articles to the book known as New and Nonofficial Remedies we find one pertaining to ingredients in which it is stated that no article shall be admitted unless its active medicinal ingredients and the amount of its ingredients in a given quantity of the article be furnished for publication. The general composition of the vehicle, alcoholic percentage, and the identity of any preservatives must be furnished. No chemical compound is admitted unless sufficient information is furnished regarding tests for identity, purity and strength, the rational formula or the structural formula must be known. No article is admitted concerning which the manufacturer or his agent makes false or misleading statements as to source, raw material from which made, or method of preparation. The identity of the actual manufacturer of the article must be furnished. No article is admitted or retained concerning which the manufacturer or his agents make unwarranted, exaggerated, or misleading statements as to the therapeutic value. No article is admitted which because of its unscientific composition is useless or inimicable to the best interests of the public or the medical profession. The council has adopted other rules concerning direct and indirect advertising which is false or misleading or marketed under a misleading name.

The council was established primarily for the purpose of gathering and disseminating such information as would protect the medical profession in the prescribing of proprietary medicinal articles, and in pursuance of this object the council examines the articles on the market as to their compliance with definite rules which were designed to prevent fraud, undesirable secrecy, and the abuses which arise from advertising to the laity. Such articles as appear to conform to the rules are admitted, and their essential features are described in the annual publication of the council, New and Nonofficial Remedies, if they come within the scope of the work. This description is based in part on investigations made by and under the direction of the council, but in part also on evidence or information supplied by the manufacturer or his agent. Such interested statements are examined critically and are admitted only if they appear to be in conformity with the evidence. The council judges an article entirely by the facts existing at the time of its admission. Previous infringements of the rule, short of intentional fraud, do not prevent the favorable consideration of an article, provided they have been thoroughly corrected.

The work of the council has been of inestimable value to the medical profession and indirectly to the public. At first the work of the council met with considerable objection and even open opposition on the part of pharmaceutical manufacturers, but it was not long before a goodly number of them began to appreciate the value of the council and the earnest efforts put forth to place drug dispensing upon a trustworthy basis insofar as it pertains to the quality and therapeutic action of the preparations that are offered for use. At the present time perhaps a majority of the reputable pharmaceutical manufacturers are supporting the council whole-heartedly, and this is indicated by the fact that practically all of their newer preparations are submitted for the approval of the council and upon being accepted that fact is made a prominent feature in marketing the preparations. On the other hand there has been a growing appreciation on the part of the physicians of the work of the council, and more and more the intelligent and thinking physicians of the United States are depending upon the council's findings when accepting and using new pharmaceutical preparations. There are, however, a few physicians who ignorantly or thoughtlessly pay little or no attention to the council's findings, and it is they who constitute the "sucker list" of a manufacturer of pharmaceutical specialties who turns out preparations of secret composition and sells them under fraudulent claims as to ingredients and efficiency.

There is no reason why any physician should be misled in this matter, for it should be the rule of every thinking physician, as a matter of protection to himself as well as to his patients, to see that the pharmaceutical specialty offered him has been passed by the Council on Pharmacy and Chemistry of the American Medical Association. If the preparation does not receive such endorsement, it may or it may not be worthy of acceptance, and in this day and age, after the long existence of the council, it is more than likely that the preparation has *not* been approved and the manufacturer is taking his chance in obtaining patrons through extravagant and even fraudulent claims concerning the merits of his preparation.

This subject would not be discussed now were it not that at the present time Indiana physicians are being bombarded with circulars and literature concerning several pharmaceutical specialties of secret composition, and physicians have been annoyed by detail men who glibly tell of the therapeutic merits of the preparation offered, and when asked as to whether the preparation is council approved they say that approval is not necessary when the formula is printed on the label. The experience of the council has shown that printing the formula on the wrapper means nothing, for not infrequently it is either a false or a meaningless formula. The honest manufacturer has nothing to fear from the Council on Pharmacy and Chemistry of the Americal Medical Association, but the gullible physician does have something to fear from the pharmaceutical manufacturers who refuse to submit their products to the council. The intelligent physician who desires to protect himself as well as his patients will prescribe only council approved products.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

The total registration at the Gary session was 892 divided as follows: Members 584, women guests 204, men guests 66, exhibitors 38.

If a majority of the voters in Indiana express their honest convictions when they cast their ballots in the coming election, then it is certain that rotten politics in Indiana will receive a knock-out blow for the present at least.

The denicotinized tobacco humbug has been exposed, and now we wonder if something will not be done to find out the status of health coffee. To our notion, coffee is coffee until you begin tampering with it, then it ceases to be coffee, so why call it coffee? You might as well talk about a kickless whiskey!

A collection agency, in boasting of the high class of its patrons, mentions in the same breath the American Medical Association and the Macfadden publications. That must please the American Medical Association, but then one occasionally must sit in church beside a human skunk, so there is no use quarreling about the announcement that the Macfadden publications and the *Journal of the A. M. A.* patronize the same collection agency.

An acquaintance who went west for his health and lived in a locality where they claimed perpetual sunshine and very little variation in the temperature from one month to another, says that the monotony of fair weather nearly drove him mad. He said that he often thought that he would give most anything he possessed if he could be back in Indiana in winter weather, tramping around in a blizzard. It is human nature to desire change, and that urge applies to weather as well as anything else.

WE haven't quite forgotten our midsummer vacation fishing trip before we begin to receive circular letters concerning a midwinter vacation trip. One of the letters from a place near the Mexican line rather interests us when it points out that doctors often need a rest in the winter as well as in the summer and should think of going to a warm and dry climate, where scenery, horseback riding, hunting, fishing and everything that makes for a real vacation is at hand. Well, anyway, it puts ideas into our heads, for the suggestion has attractive features.

FOR a year or more we have been hearing through reasonably intelligent patients that an eclectic physician, posing as a surgeon, has been telling parents that if they will squeeze and press hard on the bridge of the nose of any youngster it will "burst" adenoids and the adenoids will go away. This is on a par with an osteopath's statement that he "reconstructs the eustachian tube" by manipulation with the fingers. All of these pretenders seem to "get away" with that sort of advice, for they apparently have patients, and to all outward appearances are thriving.

A NEW stunt on the part of some hospitals is to enlarge the medical and surgical staff so that it will take in physicians from a large surrounding territory. These new staff members are good feeders in more than one sense, even though they do not add to the reputation of the hospital if given all of the privileges of the hospital. The country doctor gets a great kick out of having his name appear in the local newspaper as belonging to the staff of the hospital in a nearby large city, and in being notified that his presence at staff meetings is required.

WE hate to think that the secretary of the State Board of Health is not willing to give serious consideration to the complaint of the private laboratories concerning unjustified free service on the part of the state laboratories, and yet it looks that way. It is idle talk on the part of the secretary of the Board of Health to say that the Board cannot stop abuse of the services of the state laboratories. The trouble is of the Board's creation and the Board can stop it. Is it necessary to build a fire under a few Board members in order to get correction of evils that never should have been created?

WE are publishing an original article on "Why Physical Therapy Fails." It is a very comprehensive article and perhaps answers the question. However, our answer would be that physical therapy fails because it has been so rottenly commercialized and its virtues so grossly exaggerated. Physical therapy has a distinct place in our means of relieving the sick and suffering, but like everything else it has its limitations and it is high time that those limitations be understood. Fortunately the Council on Physical Therapy of the American Medical Association is attempting to bring order out of chaos in connection with this matter.

A United States Public Health bulletin, in speaking of the spread of contagion, makes a point that is well worth widespread dissemination among mothers when it says, "Children should be taught that there are ten objects which constantly carry contagious diseases from one person to another, and that these ten dangerous objects are nothing more and nothing less than the ten fingers." For years we have been telling children that if they will keep their fingers out of their mouths, noses, eyes and ears, they will be healthier, and that in consequence doctors will have fewer patients and much less to do.

WE have received several circular letters from a commercially inclined physician who says that for the sum of five dollars he is furnishing the very latest information concerning high blood pressure and its cure. The conscientious and ethical physician feels that he owes it to the profession, and to the public as well, to donate any new or important discoveries or developments concerning the cause and cure of disease. In other words, he does not ask to be recompensed at so much per person for information that may be of value in the treatment of disease. We hope that no Indiana physicians have been foolish enough to send five dollars to anyone in the hope of getting a cure for high blood pressure.

THE Veterans' Bureau pays a fair fee for services rendered disabled veterans of the late war. That is as it should be. However, it is nothing short of crookedness which prompts some veterans' Bureau surgeons to recommend unnecessay operations in order to exact fees for the services. Furthermore, it is a little strange that in many instances veterans of the late war sometimes are more or less obliged to submit to the opinions and service of incompetent men who as a result of political pull or influence of some kind have received appointments. The Veterans' Bureau should be interested in having nothing but first class men on their payroll, not only for the protection of the Veterans' Bureau, but in the interests of the disabled veterans.

MCINTYRE, the columnist, says that the osteopaths and chiropractors are thick in California and all are doing a rushing business in their palatial offices. Previously he commented on the fact that California had more fanatics and people with bizzare and fantastic ideas than any other state in the Union. Propagandists of every sort seem to find the sunshine of the Golden West agreeable to them, and whether they find audiences or converts makes little difference to them. Anyway, Cali-

fornia possesses more permanent as well as transient residents with crack-brained ideas than you will find in most any other place on earth, and it is no wonder that all sorts of medical fakes exist there and that medical pretenders thrive in a locality where tolerance seems to be a virtue.

We can't understand why the dairymen offer such strenuous objection to regulations covering the dairy industry in an effort to conserve the health of consumers of dairy products. Whenever a city, county or state attempts to insure a clean and healthful milk supply for the inhabitants, a great wail goes up from some of the dairymen, and in some instances much money is paid out in an effort to defeat regulatory legislation. It seems to us that turn about would be fair play and whenever a milk borne disease can be traced to a dairy that has refused or failed to comply with proper regulations, that dairy should be penalized by a heavy fine, or, in those instances where the abuse is more flagrant, the dairy should be put out of business in addition to paying a heavy fine.

The National Better Business Bureau is sending out warnings concerning "tipster" sheets which pretend to give advice concerning investments, and the value of which advice is worthless. We happen to know of a number of instances where medical men have been swindled by following the advice of tipster sheets, or have been led to invest their money through information furnished by so-called investment brokers who call physicians on the long distance telephone and claim to have wonderful inside information concerning the probable rise in the market value of certain stocks. The medical man who desires to play safe will steer clear of bucket shops and dopesters of every sort. If he has money to invest he will be wise if he consults his banker before making any investments.

A carpenter by trade who advertised that he was Buffalo's pioneer chiropractor, but never licensed to practice physical therapy, was arrested last May following the death in his office of a thirteen year old girl who was being treated. Every few days we read in the newspapers that some person has been maltreated in some way by medical pretenders of one sort or another who have never been trained to recognize disease conditions of the human body and know absolutely nothing about the application of remedial measures but who pose as doctors. We have had several instances of that kind right here in Indiana. The strange feature about this matter is that the public does not recognize the necessity of requiring knowledge, training and experience in dealing with human ills, and the public pays a high price in consequence.

The marathon dancing record was broken in Fort Wayne last month. The prize money netted each dancer less than one dollar per hour for the nerve racking time put in at the work. The injury to the physical and nervous systems of the dancers cannot be computed now, but will take its toll later. Probably if one-tenth of the time and one-tenth of the effort put in the marathon stunt had been used by each boy in helping father do the chores or yard work, and each girl in helping mother with the dishes or making the beds, the marathon dancers not only would have felt that they were very much abused, but would have turned up sick in consequence. These marathon stunts, whether they are for financial gain or for publicity, should be stopped, for they serve no useful purpose and undoubtedly carry with them an element of danger.

How often is the physician asked to refrain from telling his patient the exact nature of the ailment which brings the patient to the physician for attention. Altogether too often the physician complies with the request, and always to his own detriment as well as to the detriment of the patient. A physician should remember that he has his own interests as well as the interests of the patient at stake. If he desires to avoid being branded as either an ignoramus or a knave he will be honest in expressing an opinion, and at all times he must remember that the patient eventually will find out the truth, so why shouldn't it be given first as well as last if due consideration is given to the tactfulness with which the information is presented. Osler has said that "we are criminal participants if we refuse to tell the patient exactly the nature of his trouble," and we believe in that dictum.

A physicians' supply house is circularizing the medical men of Indiana and calling attention to the increase in income that can be brought about through the use of ultraviolet rays which, the circular says, "are useful on practically every patient who comes into the office, and an extra charge for which may be made." A self-respecting physician who receives the circular ought to feel insulted at the suggestion to commercialize the practice of medicine and swindle patients who come to him expecting honest service. Ultraviolet ray therapy is beneficial in certain cases, but it is absurd to think that it is indicated in even a majority of the cases that come to the doctor's office, and to force such treatment upon patients merely because a fee may be extracted for the service is downright dishonest, and any doctors guilty of such practices deserve to be classed with the crooks.

Now it is cut-rate laboratories. During the past few months we have received several circulars from advertised laboratories offering to do complete urinalyses from fifty to seventy-five cents, Wassermanns at two dollars, and tissue diagnoses

at three dollars. A little investigation has indicated that the laboratories are of the commercial type and are not very trustworthy. Accordingly we suggest that Indiana physicians will be wise if they have their laboratory work done by institutions of proven reputation and standing. We have enough well-trained, skilled and trustworthy laboratory men in Indiana to do all of the work for this state, and as the men running those laboratories are reputable, and members of our local and state medical societies, it is they who should have the preference rather than the commercialist outside of the state who bids for business on a cut-rate basis.

IN a previous number of THE JOURNAL, in discussing the free clinic system, we stated that we thought that Indiana was reasonably free from free-clinic abuse. Since then a prominent Indiana physician has informed us that the University clinics in Indianapolis are shamefully abused by people amply able to pay, and that some of the abuse is due directly to the activity of school nurses who drag in school children from families amply able to pay regular medical fees, and probably quite willing to do so. Such a condition of affairs deserves condemnation, and we hope that some system will be devised whereby abuse of the university clinics in this state will be in a large measure eliminated. Every city has its quota of indigent people, and Indianapolis is no exception to the rule, so there is an abundance of material in Indianapolis for teaching purposes. Charity should be granted to those deserving it, but not to others.

IT is a rather common practice for some rattle-brained automobile drivers to park their dogs on the running board or even on top of radiators while driving through city as well as country. The practice should be stopped by a law, as it is cruel and dangerous, for very frequently the dogs lose their balance and are injured or killed as the result of the fall from the moving car, or suffer a like fate as the result of being hit by passing automobiles. Up to the present time we have heard no complaint from the humane society concerning this practice, nor have we heard any wail from the anti-vivisection society which pretends to have such a humane interest in dogs and which puts forth every effort to stop animal experimentation that is done under perfectly humane methods and to the end that not only human but animal life may be saved through the experiments. In reality some of these societies that have so much sympathy for dumb animals are not very consistent.

A CHICAGO life insurance company employing a medical director who, according to the A. M. A. directory, has no affiliation with reputable medical societies, is making some demands upon certain Indiana physicians for technical information concerning patients treated, but he does not offer any compensation for the service or even give any reason why the information should be furnished. No physician is under any moral or legal obligation to furnish an insurance company or anyone else technical information concerning any patients unless compensation is offered for the time and opinion given, and the patient himself has given permission for the giving of the information. Getting something for nothing is a great indoor sport of the life insurance companies when they deal with physicians who can render them a very valuable service. Most of the requests from insurance companies in which a demand is made for valuable information as a gratuity should be thrown in the waste basket unanswered.

LAST month widespread disaster due to a hurricane which devastated portions of Porto Rico and Florida showed the necessity of having a fund set aside by the United States Government to be used in such emergencies. There is no reason why the burden of supplying aid to the needy in time of great disaster should fall upon a few generous and philanthropic individuals who upon request contribute to the treasury of the Red Cross. Several million dollars were needed to provide food, clothing, shelter, medical attention, and even burial of people who suffered from the effects of the hurricane. The government should have been ready to meet the needs instantly, and the fund could have been safeguarded by placing it at the disposition of the Red Cross under suitable restrictions. There is no reason why the Red Cross should depend upon private donations in time of widespread disaster with the loss of hundreds of lives and the destruction of millions in property. Incidentally, one of the largest contributors in time and money at a time of national disaster is the regular medical profession which responded promptly and willingly to the call for aid which had to be given by physicians at no little sacrifice of time and means.

WHEN the hurricane of last month devastated portions of Florida, and in the wake of the storm there followed injuries and disease, even pestilence, the members of the regular medical profession were the ones called upon for professional services. The osteopaths, chiropractors, naturopaths, Christian Scientists, medical pretenders, and medical fakers of any and all descriptions were not asked to contribute their services, and for the good and sufficient reason that the Red Cross officers and the people generally realize that the real, honest-to-goodness trustworthy services in time of widespread disaster can be rendered by members of the regular medical profession only. Furthermore, it is the members of the regular medical profession who answer the call at a time of widespread disaster, without thought of award of any kind whatsoever. The cultists and quacks do not offer their services because they generally

require payment for any work that they do, and in all probability the offer of their services would not be acceptable anyway. It is unfortunate that this whole matter is not analyzed to a sufficient extent by the public and a proper estimate upon the services of quacks and pretenders fixed for all time.

A surgeon with hospital connections in one of our populous Indiana cities was called to a nearby smaller city to perform an operation at the local hospital. The visit and all that pertained to it was somewhat spectacular, for the surgeon brought his own assistants and nurses who displaced the regular force at the local hospital, and at the conclusion of the operation this aggregation, with vaunted superior ability and qualifications, visited the local newspaper office, perhaps to get a cup of tea for it is unthinkable that they would go there to gain recognition that would bring about some newspaper publicity (?). However, newspaper publicity followed, and one of the local physicians who called on us and presented the eulogistic newspaper account of the affair remarked, "We medical men are getting damned tired of such grandstanding." We offer our sympathies as well as the suggestion that the medical profession should stop such exploitation on the part of any medical man and place its official stamp of disapproval upon acts that are a breach of ethics as well as common decency. Just as long as we fail to discipline our members for conduct that is unbecoming, just so long will we witness such exhibitions as called to our attention.

If there is any one thing that will kill the sale and use of physical therapy apparatus it is the extravagant advertising given it by the manufacturers of physical therapy apparatus, coupled with laudatory and unproven claims published by physicians who are ever ready to take up with something new and wax enthusiastic concerning its virtues without really analyzing their findings. There isn't a question of doubt about the good effects of various forms of physical therapy when applied and used as indicated, but the intelligent, well-trained physician is disgusted when he notes that both manufacturers and some physicians recommend certain forms of physical therapy for practically every abnormality of the human body. They even go so far as to claim specific effects when used in conditions that every trained physician knows is either self-limited in its course or but slightly influenced by any kind of therapy. The booklets sent out by some of the manufacturers of physical therapy apparatus are filled with stuff of that kind, and, very naturally, it is going to react to the disadvantage of the manufacturers and give physical therapy a black eye. It is not our intention to discredit the value of physical therapy when intelligently used, but the nauseating recommendations that manufacturers and some physicians give it indicate to us that physical therapy is commercialized to the nth degree.

Last month the health department of the city of Fort Wayne encountered a great deal of opposition in securing the enactment of an ordinance requiring the pasteurization of the milk supplies for the city following the report that there were several cases of undulant fever within the city limits caused by drinking impure milk. Many of the dairymen voiced their vigorous opposition to the sterilization of milk, and the principal objection raised was concerning the added expense which some dairymen thought would be prohibitive. Throughout the entire debate not a word came from the dairymen concerning the health of the people, particularly the health and welfare of babies and children whose diet consists largely of milk products and whose health is seriously jeopardized as a result of permitting impure milk to be distributed in the cities. Later on the mayor vetoed the ordinance as a result of the pressure brought to bear by the dairymen. It would be no more than fair if every dairyman were required to put up a bond guaranteeing the purity and healthfulness of his raw milk supply, with a penalty of paying damages in the event that any case of milk borne disease can be traced to an individual dairy. It isn't right that the public should take all the chance, and if the dairymen are so sure of the healthfulness of their milk supplies, why not back it up with a bond that will protect the people in case anything goes wrong.

Several physicians have written us concerning the standing of the Academy of Nursing having offices in the Medical Arts Building, Fort Wayne, Indiana. Again permit us to say that the enterprise in question is a "half-baked" correspondence school, organized and conducted for commercial purposes and not worthy of patronage by anyone desiring to receive adequate instruction in the art and practice of nursing. As near as we can find out, the charges depend upon the amount that can be extracted from the sucker who bites at the bait offered. Sometimes it is $125, and sometimes it is only $65, with a liberal discount for cash. The so-called instruction is scarcely worth the paper upon which it is printed, as might be expected. The whole thing comes as near being a swindle as possible without coming under the influence of the law. Unfortunately we have no laws in Indiana governing the conduct of schools, and in consequence there are all sorts of schools devoted to training but which in reality are nothing but blood-sucker enterprises for getting money without giving adequate return. The beauty culture schools are fair samples, for they encourage a lot of young girls to pay good money in an attempt to acquire a knowledge that may result in good salaries or wages, but who are unmercifully "trimmed," and the Better Business Bureaus and

authorities seem to find no way to check such a cut-throat game. So far as the Academy of Nursing of Fort Wayne is concerned, we advise physicians to warn young women, and especially those desiring to become qualified nurses, to steer clear of the institution.

The members of the Medical Society of the County of Kings (New York) believe in certified milk, and to secure a satisfactory product the milk commission of the society controls the farms, the cows, the milkers, the utensils, the bottles, and the transportation with hygienic and sanitary safeguards in order to secure a quality of milk unchanged by pasteurization. We are under the impression that there is absolutely no milk supply that will approach certified milk produced and sold under such restrictions as prevail where a milk commission rigidly enforces the necessary rules for the production of a product of superior excellence. However, the raw milk ordinarily sold usually comes very far from meeting the requirements of certified milk, and that is exactly why pasteurization becomes necessary as a protective measure in the interests of public health. While we do not believe that pasteurization to any considerable extent destroys or impairs the food value of the milk, and admitting that pasteurization does protect the public health, yet we contend that pasteurization does have a tendency to make dairies relax in their cleanliness and other efforts to produce a clean and wholesome milk. Therefore, though pasteurization is absolutely necessary for most communities, and particularly in the presence of epidemic diseases that may be carried by the milk supply, there still is the necessity for most rigid enforcement of all the general rules of cleanliness and sanitation governing the production and sale of milk supplies. The owners of some dairies are quite willing to cooperate with milk commissions or public health officials in safeguarding the milk supply, but that is not true of all dairy owners, and it is the careless and indifferent dairyman who may spread infection to innocent consumers.

The grandstanding and unethical advertising done by certain clinics in Iowa has resulted in an action in one county at least that may bear some fruit. We happen to note a lay press comment concerning the disciplining and even expulsion of doctors from one of the Iowa medical societies on the charge of unethical conduct. Being interested we wrote an Iowa physician for an explanation, and his letter is published in the Correspondence Department of this number of The Journal. So far as we know, none of the clinics in Indiana have been guilty of so much rotten advertising and commercializing of the practice of medicine as seems to have been prevalent in Iowa, and yet we admit that there is enough of it in Indiana to nauseate the respecatble element in our regular medical profession. In talking with one prominent physician of the state concerning the matter he remarked, "The difficulty in stopping this is that at least two-thirds of the members of our local medical societies are either guilty of such practices or are half-heartedly in sympahty with it. In consequence the respectable element in the society does not have sufficient votes to force the society to penalize or discipline the members that are guilty of unethical practices." It is a fine commentary upon our ideas of ethics and propriety when a society as a society is willing to keep within its ranks men who are guilty of the rankest kind of commercialism and unethical conduct. We hope that there are some societies in Indiana that have enough courage of conviction as exhibited in Dubuque, Iowa, and that they will set a good example, such as has been set in Dubuque and an account of which we publish. Just as long as we wink at infractions of our code of ethics just so long will we have within our ranks and in our medical societies men who disgrace us.

The *Democrat Chronicle* of Rochester, New York, under date of September 7, carries an account of the death of a young woman whom the coroner reports as having died "as a result of extreme negligence on the part of relatives in not providing proper medical and surgical attention, in that sole reliance was placed upon Christian Science treatment." The testimony showed that even after the patient was dead some of the Christian Scientists claimed that they did not know that death had occurred and that the death was only in a "material" sense. It also was shown that one of the relatives had insisted that the patient should try something else, as treatment by Christian Science had been given a fair chance and had not been successful, but the ministrations of the Christian Science practitioner were continued. The coroner stated that "the patient died of general peritonitis following the rupture of a pelvic abscess," and of course as that is a condition amenable to surgery it is hard to understand how those responsible for the death can escape a charge of manslaughter. In fact, it is intimated that the grand jury may be called to investigate the case. We predict that nothing will come of the matter, as the Christian Scientists have a powerful pull with the lay press and even the courts, but the evidence would seem to indicate that there never was a better chance to prove criminal negligence and contribution to the death of a patient than in the incident cited. In other words, a life was lost through criminal ignorance, negligence, and fanatic adherence to a belief that is irrational, inconsistent, and out of step with all scientific knowledge. If the courts would punish a few Christian Scientists for such criminal negligence, perhaps more lives would be saved as there would be less tendency to try to cure serious diseases by prayer alone. What a pity it is that some prominent news-

paper hasn't the nerve to come out boldly and fight for the prosecution of Christian Scientists guilty of contributing to the death of persons who have confided in them.

Who does not remember the Keeley Institute, famous in pre-prohibition days for the cure of inebriety. We can remember when drunks from all over the United States went to the Keeley Institute to sober up, and if possible get cured of the alcohol habit. Perhaps the prohibitionists would like to say that the Keeley Institute has gone out of existence, and in fact some of them do say that no such institutions exist at the present time. This is not an advertisement for the institution, but we have a letter from the Keeley Institute which says "we are still treating patients, and have been continuously for the past fifty years, and our attendance at the present time is equal to that of pre-war and pre-prohibition times." From another source we learn that most of the sanitaria that treat nervous and mental defects are today treating more patients suffering from the effects of alcoholic indulgence than they treated in pre-prohibition times. Furthermore, it is a well known fact that some of these patients have acquired the alcoholic habit since prohibition has been in effect, and anyone conversant with the facts can satisfy himself that never in the history of the United States have so many boys and girls indulged in alcoholic stimulants and do so as a regular practice. We wish to state in connection with the discussion of this subject that we are strong for prohibition if it can be enforced, and under no circumstances would we be willing to go back to the old time saloon with all of its menaces. However, there is no sense in blinding ourselves to the real facts by manufacturing statistics to bolster up a cause that has failed for want of support. We do not believe that the entire United States army and navy and all of the police forces of the country can enforce prohibition as it stands on the statute books today, and for the reason that a majority of the people are not in favor of it, and there is a constantly increasing disrespect for the law which no amount of camouflage can cover up. To our notion the solution of the problem does not rest in a continued effort to enforce rigidly regulations that the majority of the people do not wish to have enforced. There is an old saying that a half loaf is better than no loaf at all, and to our notion this prohibition question deserves some consideration from the standpoint of adopting sufficient revision to justify the belief that a very large majority of the people in the United States would support prohibition on that basis.

DEATHS

A. J. Ralphy, M.D., of New Bellsville, died August 28, aged seventy-three years. He graduated from the Kentucky School of Medicine, Louisville, in 1884.

F. M. Wells, M.D., of Jeffersonville, died September 18, aged sixty-nine years. Dr. Wells graduated from the University of Louisville School of Medicine in 1882.

Herschel C. Robinson, M.D., of Martinsville, died August 31, following a short illness. Dr. Robinson was seventy-three years of age. He graduated from the University of Louisville School of Medicine in 1872.

Thomas C. Kennedy, M.D., of Indianapolis, died suddenly at his home in Indianapolis, September 14. Death was caused by cerebral hemorrhage. Dr. Kennedy was sixty-six years of age. He was well known by physicians throughout the state and was regarded as one of the foremost authorities in America or the use of radium. He served as president of the Indiana State Medical Association in 1910. He graduated from the Kentucky School of Medicine, Louisville, in 1883 and was a member of the Indianapolis Medical Society, the Indiana State Medical Association, the American Medical Association and the American Radium Society.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in The Journal of The Indiana State Medical Association. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

Dr. O. S. Jaquith and Miss Alma Bates Cook, both of Indianapolis, were married August 30.

Dr. C. Edward Harris, formerly of Bloomington, Indiana, has announced that he is now practicing medicine in Hollywood, California.

The office and equipment of the late Dr. M. C. Clokey have been purchased by Dr. W. C. Day, of Seymour, who will go to Huntington to practice.

Dr. O. G. Brubaker, of North Manchester, has announced the opening of an office in Wabash. He will also continue his usual practice in North Manchester.

Dr. Alfred Henry and Dr. Irving W. Lemeaux have been reappointed members of the governing body of the Sunnyside Sanitarium for four-year terms.

The Clinical Congress of Physical Therapy and the seventh annual meeting of the American College of Physical Therapy was held at the Stevens Hotel, Chicago, October 8 to 13.

Dr. and Mrs. M. B. Catlett and Dr. and Mrs.

G. E. Moats, of Fort Wayne, have recently returned from Europe, where Dr. Catlett and Dr. Moats took postgraduate work in Vienna.

THE Monroe County Medical Society will hold its first meeting of the year September 19, at Bloomington. Dr. Matthew Winters, of Indianapolis, presented a paper on "Progress in Pediatrics."

DR. MARTHA ANDERSON has resigned her position as resident physician at Healthwin Hospital, South Bend, to accept the position of medical director of the Adams County Sanatorium, at Quincy, Illinois.

DR. JAMES Y. WELBORN, of Evansville, has announced that he has purchased a home in Evansville which will be used as a hospital for colored patients. The institution will be known as the Walker Hospital Annex.

MEMBERS of the Huntington County Medical Society held their monthly meeting at the Hotel LaFontaine, September 11. Dr. Leon G. Zerfas, of Indianapolis, presented a paper on "The Primary Pernicious Anemia."

DR. SHELBY WISHART, cardiologist of the Walker Hospital, has been appointed cardiologist for the St. Mary's Hospital and the Deaconess Hospital in Evansville. Electro-cardiographic machines have been installed in both hospitals.

DR. KARL RAMUS, who has been the medical officer in charge of the United States Marine Hospital, at Evansville, for the past seven years, has been transferred to New York. Dr. K. E. Miller, of the United States Marine Hospital of New York, succeeds him.

DR. ALBERT E. BULSON, of Jackson, Michigan, died September 4, aged eighty-two years. Dr. Bulson was a former president of the Michigan State Medical Society and was a Civil War veteran. He was the father of Dr. Albert E. Bulson, Jr., of Fort Wayne, editor of THE JOURNAL.

THE International Assembly of the Inter-State Post Graduate Medical Association of North America will be held at Atlanta, Georgia, October 15 to 19, 1928. Pre-assembly clinics will be held October 12 and 13. Complete information and program may be obtained by writing to Dr. William B. Peck, managing editor, Freeport, Illinois.

THE regular monthly clinic program of the Walker Hospital Clinic, Evansville, was held September 19. The program consisted of presentation of interesting cases by Dr. W. R. Davidson, Dr. A. E. Allenbaugh, Dr. J. W. Visher and Dr. K. E. Miller, and a paper on Auricular Fibrillation by Dr. Shelby W. Wishart. A large number of physicians from the Tri-State area attended the meeting.

THE Indiana Hospital Association will hold its next annual convention in Indianapolis April 11 and 12, 1929. Officers of the association are: Dr. Albert G. Hahn, of Evansville, president; Dr. William A. Doeppers, Indianapolis, first vice-president; Miss Ada B. Strayer, Wabash, second vice-president; Miss Gladys Brandt, Logansport, executive secretary, and Mrs. Hazel B. Presser, of Kokomo, treasurer.

THE Indiana University School of Medicine plans this winter to have several eminent orthopedic surgeons give clinics and addresses at the Riley Hospital. The first of these will be given by Dr. Edwin Ryerson, professor of orthopedics, Northwestern University Medical School of Chicago, on Thursday, October 18. He will give an operative clinic at the Riley Hospital at 1:30 p. m. on the above date and an address at the medical school at 8:00 p. m. The physicians of the state are cordially invited to attend this clinic and address. Those wishing to attend the clinic are asked to write Dr. L. L. Shuler, in care of the Riley Hospital. The names of the surgeons giving later clinics will be announced shortly in THE JOURNAL.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

ABBOTT LABORATORIES:

Potassium Bismuth Tartrate with Butyn—D. R. L., 20 cc.

PARKE, DAVIS & CO.:

Scarlet Fever Streptococcus Toxin for Skin Test—P. D. & Co.

E. R. SQUIBB & SONS:

Ephedrine Hydrochloride—Squibb.

SWAN-MYERS CO.:

Syrup Ephedrine Hydrochloride—Swan-Myers.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION GARY SESSION

SEPTEMBER, 1928

HOUSE OF DELEGATES

The first meeting of the House of Delegates of the seventy-ninth annual session of the Indiana State Medical Association was held in the tea room of the Hotel Gary, Gary, Indiana, September 26, 1928, at six-thirty p. m., the president, Dr. George R. Daniels, of Marion, presiding.

Roll-call of delegates by Dr. George Miller, of Logansport, chairman of the Committee on Credentials, showed a quorum present, and the president declared the House of Delegates in session for the transaction of business.

Moved by Dr. A. L. Marshall that the minutes of the previous meeting as printed in THE JOURNAL be

accepted and that the reading of the minutes be dispensed with. Motion seconded and carried.

The following reference committees were appointed by the president, in accordance with Chapter IX, Section 1, of the By-Laws of the Association:

REFERENCE COMMITTEES

COMMITTEE ON SECTIONS AND SECTION WORK

J. F. Loomis, Marion (Chairman)—Grant County
Frank W. Lose, Decatur—Adams County
L. L. Harding, Frankfort—Clinton County
I. N. Trent, Muncie—Delaware-Blackford County
P. N. Schoen, New Albany—Floyd County

COMMITTEE ON RULES AND ORDER OF BUSINESS

H. P. Graessle, Seymour (Chairman)—Jackson County
Ross Cooper, Carmel—Hamilton County
J. E. Nixon, Portland—Jay County
E. C. Totten, Madison—Jefferson County
R. G. Moore, Vincennes—Knox County

COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

H. H. Martin, Laporte (Chairman)—Laporte County
Boaz Yocum, Coal City—Owen County
J. H. Walker, Scottsburg—Scott County
Mary F. Ritter, Angola—Steuben County
J. T. Oliphant, Farmersburg—Sullivan County

COMMITTEE ON PUBLIC POLICY AND LEGISLATION

H. G. Hamer, Indianapolis (Chairman)—Marion County
W. H. Stemm, North Vernon—Jennings County
J. V. Carter, Tipton—Tipton County
D. C. Wybourn, Ossian—Wells County
W. B. Siders, Warsaw—Kosciusko County

COMMITTEE ON PUBLICITY

Walter C. McFadden, Shelbyville (Chairman)—Shelby County
A. L. Marshall, Indianapolis—Marion County
A. D. Sweet, Martinsville—Morgan County
F. T. Romberger, Lafayette—Tippecanoe County
D. A. Bickel, South Bend—St. Joseph County

COMMITTEE ON HYGIENE AND PUBLIC HEALTH

A. M. Hayden, Evansville (Chairman)—Vanderburgh County
O. O. Alexander, Terre Haute—Vigo County
O. G. Brubaker, North Manchester—Wabash County
S. A. Roberts, Salem—Washington County
George R. Douglas, Valparaiso—Porter County

COMMITTEE ON AMENDMENTS TO THE CONSTITUTION AND BY-LAWS

Charles Good, Huntington (Chairman)—Huntington County
H. B. Turner, Owensburg—Greene County
Jesse E. Ferrell, Fortville—Hancock County
W. R. Sparks, Pendleton—Madison County
C. F. Hope, Shoals—Orange County

COMMITTEE ON REPORTS OF OFFICERS

Thos. W. Oberlin, Hammond (Chairman)—Lake County
J. F. Bowen, Rushville—Rush County
W. H. Williams, Lebanon—Boone County
Ira M. Sanders, Greensburg—Decatur County
A. C. Yoder, Goshen—Elkhart County

COMMITTEE ON CREDENTIALS

George D. Miller, Logansport (Chairman)—Cass County
J. R. Burlington, Attica—Fountain-Warren County
J. H. Clark, Connersville—Fayette County
O. T. Graves, Princeton—Gibson County
S. C. Waters, Middletown—Henry County

COMMITTEE ON MISCELLANEOUS BUSINESS

E. M. Van Buskirk, Fort Wayne (Chairman)—Allen County
Walter L. Portteus, Franklin—Johnson County
H. C. Ragsdale, Bedford—Lawrence County
J. E. Yarling, Peru—Miami County
T. Z. Ball, Crawfordsville—Montgomery County

At this time the president called on Dr. E. M. Shanklin, chairman of the General Arrangements Committee, who expressed the pleasure of the Lake County Medical Society in entertaining the State Association, and announced the various forms of entertainment provided for the members and guests.

The reports of officers and standing committees, having been printed in THE JOURNAL, were referred to the proper reference committees, each chairman being permitted to make any explanation or addition to the report already published.

Medical Defense. DR. A. L. MARSHALL, Chairman Executive Committee: You will notice that this year we spent $1,650 for medical defense, which is accounted for in this manner: We have a schedule to which we adhere in most cases, and on investigating this case we found from the court records that there actually had been thirteen trial days. We allow $50.00 for preparation of the case, $50.00 for each trial day, and $50.00 for closing the case. There had been two trials, thirteen trial days, so we settled on that basis and paid the firm $750.00. Another $500.00 fee was charged in a case that had been hanging for two or three years, and in which a very long and expensive transcript had been filed with the supreme court.

I merely call attention to this in explanation of the unusual expense. We have a record made of the receipts and expenditures of this committee since 1912. In that time we have received $32,228.75, and the committee has spent $14,986.42, leaving a balance that has been turned over to the general fund of $17,242.33.

Bureau of Publicity. DR. W. N. WISHARD, Chairman of Bureau of Publicity: We have a rather long report, and I will not read it, but the Bureau in presenting its sixth annual report wishes to express its appreciation of the cordial approval of its work that has come from the profession in and outside of the state. We are receiving letters from all over the country asking for an outline of the method of organization of this work of the Bureau. Within the past few weeks we have received letters from abroad, one from Berlin, asking for copies of our releases, and asking questions about the method of conducting the Bureau. The work of the Bureau has become a little heavier each year, and, as you will see by this report, we have given weekly releases to the newspapers over the state. These releases are published in some ninety journals, weekly and daily newspapers over the state; also in various monthly periodicals, and we constantly have calls for copies of releases on special subjects.

In addition, as you know, we are providing lectures and addresses by selected representatives of the Indiana State Medical Association on special topics. Our rule is never to respond to a request from a non-professional club or organization of any kind unless the request is approved by the members of the local medical society. The members of the local medical societies, I may say, have appreciated very much the cooperation we have given. We are pleased with the constant appeals to the Bureau, through the suggestion and influence of members of the local medical societies, and from the organized bodies themselves.

We have, as you see, quite a long list of the places over the state where representatives of the State Medical Association have made addresses in response to local requests.

I think we have been doing better work this year than ever before, and the work in the very nature of things is educational and progressive. We are anxious for your suggestions; we are anxious to conduct the work in a way to meet your approval; we are anxious to be efficient and to accomplish something by our work.

The report is too long to read at this time, and I only venture these remarks because they may answer some questions in your minds. We have had from time to time a little criticism. We are glad of it. We want to be criticized; we want your suggestions and your help. We may make mistakes. Occasionally we have found—and I ask your sympathetic consideration of this point—that we have made a mistake in sending certain physicians to certain societies to talk on certain subjects. We send

to the secretary of every county society, or to some representative of the local medical society, a confidential letter, after any man has been out to represent the Bureau or the State Association, asking whether his address was acceptable. I say this openly because we want you to know that we are careful and are trying to conduct a better and better educational program that will meet your approval. We have in only two or three instances received criticisms of the persons sent out, and I think probably they were justified.

I want to thank you very much for your support; I thank Dr. Bulson, editor of THE JOURNAL, for the constant support he has given the work of the Bureau, and also Mr. Hendricks, the executive secretary, for his careful and constant attention to the details of the Bureau.

Industrial and Civic Relations. DR. F. S. CROCKETT, Chairman of Committee on Industrial and Civic Relations: I have nothing particular to add to my report, but I would like to call the attention of the delegates to certain pertinent facts about the activities of this committee. If Dr. Bulson does not emphasize the fact that the committee is operating, we get little business. When he announces in THE JOURNAL something about this committee, then we will get a half dozen cases to settle. The committee is not particularly keen on drumming up business, because every case that comes in is handled in a rather laborious manner; but still we do want to function to the satisfaction of the members of the Association and carry out the purpose for which the committee was created. The policy and efforts of the committee have been fairly satisfactory, both to the complaining doctors and to the insurance people, where there is a dispute concerning fees. Matters other than that we do not consider as coming within our province. The committee hopes to exert some influence in legislative matters in which this Association is interested.

THE PRESIDENT: Dr. Frank W. Cregor is the chairman of the Budget Committee, but he is unable to be present. This report was not printed in THE JOURNAL along with the treasurer's report, as the budget figures and the actual expenditures will not be available for comparison until the first of the year, but Dr. Cregor has made copies of the report as far as he could go.

The president then presented the president-elect, Dr. Charles E. Gillespie, of Seymour.

Under the head of "Communications" the secretary read the following telegram:

"Detroit, Michigan, September 25, 1928.

"Tom Hendricks,
"Executive Secretary Indiana State Medical Society,
"Gary, Indiana:

"Michigan State Medical Society sends fraternal greetings to our esteemed colleagues in Indiana. As we both in annual session seek to attain ideals and discharge our communal obligations, may we be guided rightly to perpetuate the prestige that the years have vouchsafed to our profession. Our interests are common. In that spirit we salute you.

"F. C. WARNSHUIS,
"Secretary."

DR. A. E. BULSON: I move that the Indiana State Medical Association, through its House of Delegates and our worthy secretary, send a telegram to the Michigan State Medical Society, properly phrasing our thanks for the message we have received and wishing them Godspeed in their work. (Taken by consent.)

THE SECRETARY: The House of Delegates passed a resolution at the last annual session recommending that "The Bureau of Publicity be given authority to act as a special committee to confer with similar committees appointed by voluntary health agents on matters pertaining to the work of these health organizations and their relation to the medical profession." This was done "in order that those difficulties that often have arisen between public health agents and the organized medical profession will be avoided, and that detailed study may be made of the situation as it exists in Indiana."

In accordance with this resolution, a committee from the Indiana Tuberculosis Association met with the Publicity Bureau on January 16th and invited the State Medical Association to send a representative to the annual meeting of the Indiana Tuberculosis Association at Gary. The committee appointed Dr. J. O. Parramore, of Crown Point, to attend that meeting, and his report of that meeting appeared in the April number of THE JOURNAL.

(This report was read by the secretary, and on motion of Dr. Romberger, duly seconded, was adopted.)

THE SECRETARY: The following communication was received by the Executive Committee at its regular monthly meeting, August 12th, from the Child Welfare League. The Executive Committee did not take any action and does not desire to do so until it hears from the House of Delegates:

"Kalamazoo, Michigan, Aug. 2, 1928.

"Mr. T. A. Hendricks, Ex. Sec.,
"Indiana State Medical Association,
"Indianapolis, Indiana.
"Dear Mr. Hendricks:

"Enclosed are three copies of a questionnaire compiled by the above organization (Child Welfare League) to guide us in making some necessary changes in our free infant clinics this fall.

"Will you kindly fill one out, stating whether or not your State Medical Association has gone on record as favoring or opposing such clinics?

"As to the other copies, would it be possible for you to mail them to some member of the Association in cities having a population of 50,000 to 100,000 in your state? It has been impossible for us to secure the names of county secretaries, but if you can assist us I am sure we can get the points of view of various cities now facing the same problem Kalamazoo is.

"Thanking you in advance for this favor, I am,

"Yours very truly,
"HELEN DALY, Secretary."

On motion, duly seconded and carried, this communication was laid on the table.

DR. W. N. WISHARD: I have here a resolution prepared by Dr. Cregor, who is ill and unable to be present. I will ask Mr. Hendricks to read it, and I move its adoption. It is purely educational and is in fact in cooperation with the work of the State Board of Health:

A RESOLUTION CONCERNING THE ATTITUDE OF THE MEDICAL PROFESSION OF INDIANA TOWARDS THE QUESTION OF RABIES.

WHEREAS, There has been and is at the present time an epidemic of rabies in the State of Indiana, and as a result of such epidemic many persons are taking the Pasteur antirabic treatment, and

WHEREAS, Most of such persons first seek the advice of their physicians, and many physicians are referring such patients to the Indiana State Board of Health for treatment instead of treating them themselves or referring them to physicians who will treat them, and

WHEREAS, The hydrophobia law specifically states that the State Board of Health shall give treatment to those who are certified to it by the local township trustee and the local health officer as being in need of the treatment, and that such person or persons have no visible means with which to pay for such treatment, and

WHEREAS, In addition to the requirements of the law, the State Board of Health goes even further and requires all patients to make an affidavit that they are unable to pay for such treatments, and

WHEREAS, It is generally known that many of the persons who are certified to the Board of Health for such treatment do have visible means with which to pay for such treatment, and

WHEREAS, It is known that most of such persons

have been referred to the proper authorities by the family physician in the first place; it is hereby

Resolved, That a campaign of education concerning the nature of such treatment be brought to the attention of our county medical societies in order that more of these patients may be taken care of as private patients and not illegally be made wards of the state.

(The motion of Dr. Wishard was seconded by Dr. Oberlin, and carried.)

On motion of Dr. Romberger, duly seconded and carried, the secretary was instructed to send messages of sympathy to Dr. F. W. Cregor, ex-president of the Association, and Dr. William Doeppers, treasurer of the Association, both of whom are ill in the hospital, with best wishes for their speedy recovery.

On motion, duly seconded and carried, the president appointed the following committee to draw up suitable memorials regarding the death of Dr. John H. Oliver and Dr. T. C. Kennedy, ex-presidents of the Association: Charles H. Good, W. R. Davidson and Charles N. Combs.

Under the head of "Unfinished Business" the secretary read a resolution presented by Dr. A. J. Hostetler at the 1927 session of the House of Delegates, "That the By-laws of this Association be amended whereby the Indiana State Board of Health may name a delegate to the Indiana State Medical Association, which delegate shall be a physician." This resolution at that time was laid over one year, to be taken up as unfinished business.

Dr. A. J. Hostetler: As the man who made that motion a year ago, I find that there are so many questions to be ironed out, and we have not had enough meetings with the State Medical Association members to work out just exactly what we want. I will, therefore, be perfectly satisfied to lay it on the table until we understand one another more thoroughly. (Taken by consent.)

Dr. A. L. Marshall: I would like to move that Section 2 of Chapter XII of the By-Laws be stricken out:

"Section 1: Seventy-five cents out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

"Sec. 2: Whenever such fund shall exceed the sum of Six Thousand Dollars ($6,000.00), the surplus over and above this amount shall be turned back to the general treasury, or may be used for such other purposes as the House of Delegates or Council may direct."

The reason is this: The tax is levied for a specific purpose and it is turned into another purpose. We have had quite a good deal of agitation on the part of the State Board of Medical Registration and Examination concerning collecting fees and having them turned into the state fund, which act has been pronounced eminently unfair, and your medical defense committee has been handicapped a great deal by not being able to count upon the funds raised for a specific purpose. We take the stand that this fund is collected for a specific purpose and it has been diverted to other uses.

Also Sec. 5, which reads:

"Sec. 5: The Treasurer shall be the custodian of the Defense Fund, separately kept, and shall give an additional bond of $6,000.00."

I move that this be changed to read:

"Sec. 5: The Treasurer shall be the custodian of the Defense Fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee."

On motion of Dr. A. E. Bulson, duly seconded and carried, this matter was referred to the Reference Committee on Constitution and By-Laws, to be reported on at the next meeting of the House of Delegates, Friday morning.

Under "New Business" Dr. John M. Pulliam, of Fort Wayne, offered the following resolution:

RESOLUTION ON POLICY OF STATE BOARD OF HEALTH

Preamble: We, the members of the Indiana State Medical Association, are in full sympathy with the activities of the State Board of Health insofar as they pertain to features and problems of public health. We are not in sympathy with those activities in which the state enters into competition with practicing physicians in the diagnosis or treatment of cases which have no direct bearing upon the health or welfare of the community. The statute by which the State Laboratory of Hygiene was authorized defines and limits the activities of the laboratory to the making of examinations as an aid to the enforcement of public health measures, and for no other purpose.

At present the State Laboratory of Hygiene makes free examinations of practically every kind of specimen sent in by physicians, regardless of whether such examination has any bearing upon the enforcement of public health measures, and regardless of whether the patient is indigent and hence a proper beneficiary of free public medical service. A natural outgrowth of this situation is that physicians send all types of specimens from patients who *can* and *do* pay the physicians for the service which the State Laboratory renders free at the expense of the taxpayer. So prevalent has this custom become that many physicians openly state that they make no charge for the examination that is made free by the State Laboratory, but that they charge $5 for drawing the blood or collecting the specimen and sending it to the Laboratory. The records of the State Laboratory show that a huge volume of Wassermanns and of other examinations is being done on physicians' private cases at public expense. A policy which makes it possible, and even invites physicians to benefit from public service at the expense of the public funds, is indefensible and demands revision.

We recognize the fact that the work of the State Hygiene Laboratory grew to its present proportions and scope as a process of development in accordance with this policy. We also realize that there should be some definite policy of reform adopted and rigidly adhered to, which policy should, and we trust would, limit the activities of the State Hygiene Laboratory to a rational interpretation of its function as defined by statute.

Therefore, Be It Resolved, by the House of Delegates of the Indiana State Medical Association, that

Whereas, The State has the right and duty to conduct and maintain adequate State and County health boards, and insofar as it fulfills all these above indicated rights and duties should have and does have the unqualified support of the medical profession in the fulfillment of these varied rights which in no sense conflict with the principles herein set forth; and

Whereas, Certain abuses of the above rights and duties are practiced by the State Board of Health Laboratory, which abuses if unchecked are bound to develop into State medicine; and

Whereas, The indicated abuses have been and still are indulged in by the State Laboratory or its agents, we, therefore, offer the following as a platform of principles upon which the Indiana State Medical Association should stand:

1. That while the Indiana State Medical Association heartily supports the proposition that the State should care for its mental and moral defectives and its indigent sick, it unqualifiedly condemns the tendency of the State to enter into competition with licensed physicians in the practice of medicine, surgery, and clinical pathology.

2. That it condemns the socialistic efforts of the State to force the expense of private laboratory work upon the taxpayers under the guise of public health.

3. -We commend and pledge our support to the efforts of the State Board of Health to recognize and properly to safeguard all cases of diphtheria, typhoid fever, and similar contagious diseases. Such laboratory tests as are an aid to these would be regarded as within the intent of the statute. The performance of the Wassermann test for public institutions whose inmates are in any sense

wards of the State could not be criticized, but we maintain that this test should be performed by the Public Health Laboratory only for the inmates of such institutions, public venereal clinics, and the indigent.

The various routine examinations of sputum, urine, and feces, the diagnosis of tissues from surgical cases and from autopsy examinations, toxicological examinations, and the making of microscopic and other examinations of blood, we regard as a direct invasion of the field of diagnostic medicine. Such examinations are not an aid in any way to the enforcement of public health measures. The State in making such examinations at once enters into competition with physicians whose specialty is clinical diagnosis, or clinical pathology, and at the same time pauperizes the patients at the expense of the taxpayers.

If such examinations should be made only upon specimens from indigent patients there would remain no grounds for criticism. But the indigent already are cared for in this field by the various public hospitals, dispensaries, and clinics. The bulk of such examinations which are now made by the hygienic laboratories are upon specimens sent by physicians from their own private cases that are in no sense public health problems and do not fall within the scope of the statute. If it were desired to maintain a laboratory service for the benefit of indigent patients occasionally treated by physicians as private cases, then this should be safeguarded rigorously against the abuses that now exist. This might be satisfactorily accomplished by requiring the physician to sign a statement such as the following, which should be printed upon the card accompanying the specimen:

"I hereby certify that (Patient's name and address) from whom this specimen was taken is indigent to the degree that he is unable to pay for medical attention. And I further certify that I am making no charge whatsoever for my services in this case.

(Signed) "_____, M.D."

Or, following the plan of the State of Michigan, the State Laboratory to require the name and address of each patient, so that they may notify the patient that the work was done without charge.

On motion of Dr. A. E. Bulson, duly seconded and carried, this resolution was referred to the Reference Committee on Public Policy and Legislation, report to be made at the Friday morning meeting of the House of Delegates.

No further business appearing, the House of Delegates adjourned until Friday morning at seven o'clock.

THOMAS A. HENDRICKS,
Executive Secretary.

SECOND MEETING

The Friday morning (breakfast) meeting of the House of Delegates was held in the tea room of the Hotel Gary, convening at seven o'clock, the president, Dr. George R. Daniels, presiding.

Roll-call of delegates by Dr. George D. Miller showed a quorum present, and the House proceeded to the first order of business, the election of officers, which resulted as follows:

President-elect—Angus C. McDonald.....Warsaw
Treasurer—Wm. E. Doeppers (re-elected), Indianapolis
Delegates to A. M. A.:
David Ross.....Indianapolis
Harry Elliott.....Brazil
Alternates:
F. S. Crockett.....Lafayette
Robert M. Moore.....Indianapolis
Councilors:
First District—John H. Hare.....Evansville
Third District—To be elected later.
Sixth District—B. G. Keeney.....Shelbyville
Ninth District—F. S. Crockett.....Lafayette
(The above Councilors had been elected by their respective districts, and the House of Delegates ratified their election.)

Place of Meeting for 1929—Evansville.

Dr. Charles H. Good reported that telegrams had been sent to Dr. F. W. Cregor and Dr. William E. Doeppers, and moved that a telegram of sympathy on account of the death of his wife be sent to Dr. Ira E. Perry (delegate), of North Manchester. (Taken by consent.)

Moved by Dr. E. E. Padgett that the House of Delegates express its thanks and appreciation to the Lake County Medical Society for one of the best sessions ever held by the Association; also that a vote of thanks be extended to the Gary Commercial Club, Capt. H. S. Morton, president; the Gary Chamber of Commerce, Mr. J. U. Nichols, secretary; the United States Steel Company, Mr. W. P. Gleason, superintendent; the Hotel Gary, Mr. S. E. Duffey, manager; the residents of Gary, for various courtesies extended to the members of the Association; and to Miss Kay Oberlin and Leslie Parry, of the *Lake County Times,* and Mr. West, of the Gary *Post-Tribune,* for the generous press notices given the various meetings and activities of the Association. (Motion unanimously carried by rising vote.)

At this time the president-elect, Dr. Angus C. McDonald, was escorted to the platform.

DR. ANGUS C. MCDONALD, President-Elect: I simply want to thank you for the honor. I can assure you that a young man like myself appreciates these things. It seems that once in a while a man gets a surprise. A few years ago I was in politics in our town and I had a surprise, but not as agreeable as this. I hope I will prove worthy of your trust. It is new business to me. I have presided over our own little meetings, but never over a group of men such as we have here. But I will try to learn, and I know I have good men to fall back on. I will do the best I can.

The president then called for reports of Reference Committees:

REFERENCE COMMITTEE ON SECTIONS AND SECTION WORK

Report as printed in THE JOURNAL endorsed and on motion duly seconded and carried was ratified by the House.

REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

Report as printed in THE JOURNAL endorsed. On motion duly seconded and carried was ratified by the House.

REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HOSPITALS

Report as printed in THE JOURNAL endorsed and on motion duly seconded and carried was ratified by the House.

REFERENCE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Your Reference Committee on Public Policy and Legislation begs to report as follows:

Approval of the reports and recommendations of the standing Committee on Public Policy and Legislation and of the Committee on Civic and Industrial Relations, as published in the Handbook for Members of the House of Delegates and already presented to the House of Delegates, and recommends the adoption of these reports.

The committee also begs to report on the resolution presented by Dr. Pulliam of Fort Wayne, that while the resolution should have been presented in more condensed form, it nevertheless presents principles which have been the historic policy of the Indiana State Medical Association, and the committee, therefore, recommends the approval of the resolution.

H. G. HAMER,
Chairman.

Moved by Dr. George D. Miller that this resolution of Dr. Pulliam's be received and laid on the table, to be acted on next year. Motion seconded, but lost.

DR. JOHN M. PULLIAM: There has been some criticism of the length of this resolution, but it is impossible

to tell the facts without putting them down on paper. However, every medical man knows that this abuse mentioned in the resolution is going on in the State Board of Health. I am not interested in the state laboratory as I do not send any work to it. I send my work to private laboratories, and they do my indigent work and I have never had them ask me to pay a bill for a patient that does not pay me.

Dr. King is simply building up a machine in Indianapolis to perpetuate himself in office. He is a politician; I know because I lived among them for twelve years. I understand that the president of the State Board of Health is not a member of any medical society. I am a member of a medical society—perhaps not a very good member—but I do feel that the State Board of Health should not make examinations free except in case of epidemics or where the patient is indigent. I know of an example where three years ago fifty-two Wassermann examinations came into the State Board; eleven were marked "indigent"; eleven "not indigent," and the rest were not marked at all, but they were all done.

DR. GEORGE D. MILLER: I did not offer the motion to table this resolution because I wanted to railroad it out, but it is a lengthy resolution and should be studied by us all, and if we pass the resolution as it is without thorough investigation I believe we will die with an unpardonable sin upon our souls. I believe it is a serious proposition, one that should be handled with gloves.

DR. GEORGE J. GEISLER, South Bend: I believe the committee that passed on this resolution is composed of a group whose judgment we can rely on. I do not believe the president would have referred it to this committee if he did not think that their recommendation would be worth something to this body. We have in South Bend a clinical laboratory of which we are very proud, one which is functioning ethically, a laboratory whose director has been in position to check up a number of doctors in our community, and he has found that the evil which is reported in this resolution, a remedy for which has been suggested, does exist and the charges are true. I believe that not only must we get after the State Board of Health to remedy this condition, but we must do a little missionary work in our own ranks. Let us find out who these men are who abuse the privileges of the state laboratory. I realize that the laboratories throughout the state are not very numerous, but how are we to encourage the establishment of good laboratories, those whose quality of work and whose leadership you cannot deny is of the best—how are we to encourage that kind of work if we have a State Board of Health going openly into competition and not even asking us whether a case is indigent or not? I say to you, gentlemen, that it is about time we wake up to the situation and decide this thing now. I think state medicine is heading this way rapidly, and this is one of the ways they are doing it. I understand that the clinical pathologists are trying to put this thing through in all the states of the Union, and I hope the time will come when they will accomplish it throughout the country. Speaking for the delegates from South Bend, we are heartily in favor of this resolution and we ask that consideration be given to it.

DR. A. E. BULSON: No doubt everyone here knows how I feel on this subject. There is a great principle involved, as I have brought out in THE JOURNAL. I have had a number of conversations with Dr. King on this subject—I had a two-hour talk with him yesterday afternoon. Much to my surprise Dr. King wants *us* to take the initiative in pointing the way to correct some of the evils which exist and are of his creation. I told him very frankly that I thought he should adopt measures to correct his own mistakes. At the same time we must recognize the fact that we ourselves will have to do a little disciplining and penalizing of our members. It is unfortunate, and I regret to have to say it, that there are members of this Association who in my judgment are but little short of dishonest when they send samples of blood to the state laboratory, blood taken from wealthy patients, and charge the patients for the service, not only for drawing the blood but for the examination itself. Aside from such dishonesty there is a great principle involved, and that is that the State Board of Health is helping to pauperize the people and encouraging loss of self-respect. Dr. King says he does not know of any way to stop it, that he has tried out a plan such as they have in Michigan—in fact, he told me Indiana started it before Michigan—and he says it does not work out. It seems to me that if he wanted to stop the practice he could find a means. I suggested that he stay over for this meeting and help formulate a plan, but he said it was impossible, that he had to get back to Indianapolis on important business.

I quite agree with Dr. Miller that it is a big problem and we must not go at it in a slip-shod way, nor should we railroad anything through. I believe that some solution of the problem can be effected by the State Board of Health, and that the State Board alone, of its own initiative, should put a stop to abuses of which the resolution complains. On the other hand this Association should put its foot down on the questionable practices that have been followed by some of the members of this Association in connection with the abuse of state laboratory service. We also should make it a matter of record that we are not in sympathy with the plan that is now in force at the laboratory of the State Board of Health.

DR. ALFRED S. GIORDANO, South Bend: The State Board of Health not only will do work without investigating whether the patient is entitled to free work, but they actually solicit not only individuals but corporations. A short time ago the Indiana-Michigan Electric Company, a corporation—very wealthy—was asked by the Board of Health to send them water to be analyzed, while we right there in South Bend are equally as competent to do the work. They go throughout the country to medical societies and speak of their service, how easy it is for doctors to send specimens to them. I do not think that sort of thing is justifiable. They make no attempt to stop it. In fact, they encourage such practices.

DR. JOHN E. YARLING, Peru: I believe the State Laboratory is doing a good service. I have no laboratory and it is essential that I get good service. It is possible that the State Laboratory oversteps its function in an effort to please the doctors and get their good-will. We all know that there are some doctors taking advantage of this. It is not the first time that doctors have taken advantage of conditions, and it will not be the last time, but I do feel that if we put too many restrictions on the State Board some people will suffer in order that some doctor who has taken advantage of it should be shown up. I think we should criticize the doctors instead of the State Board of Health. If some of the doctors are not sending specimens to accredited laboratories and paying for examinations we should not criticize the State Board too severely. I am not in favor of state medicine; I am opposed to it; but if we put too many restrictions around the State Board somebody will suffer.

DR. E. E. EVANS, Gary: It seems to me that this resolution, together with the sentiments expressed at this meeting, should be referred to the standing Committee on Public Policy and Legislation, with instructions to get in contact with the State Board of Health and work this problem out before the next session. I move that this whole matter be referred to that committee, with power to act.

(Motion seconded by Dr. H. M. Hall, and carried.)

REFERENCE COMMITTEE ON PUBLICITY

Report as printed in THE JOURNAL endorsed and on motion duly seconded and carried was ratified by the House.

DR. A. E. BULSON: I do not think you appreciate the

amount of work the Bureau is doing. A good deal of it falls on the shoulders of Dr. Wishard, who goes to the Association office several times a week to discuss plans and arrange for releases or provide speakers for various meetings. The work is well done, as the comments from all over this country and even abroad will show, and I think it is no more than right that we should show our appreciation by a vote of thanks. I, therefore, move that this House of Delegates extend its heartfelt thanks to that committee for the splendid work it is doing.

(Motion seconded and carried by rising vote.)

REFERENCE COMMITTEE ON CONSTITUTION AND BY-LAWS

DR. CHARLES H. GOOD: The Committee on Constistitution and By-Laws, on the resolution presented by Dr. A. L. Marshall, of Indianapolis, beg leave to report as follows:

"The committee recommends the adoption of the resolution to amend Chapter 12 concerning medical defense; that Section 2 be dropped from the By-Laws, and Section 5 be amended to read: 'The Treasurer of the Indiana State Medical Association shall be the custodian of the Defense Fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. He shall pay out money from this fund only on the signed order of the Chairman of the Executive Committee and countersigned by the President, and the Chairman of the Council.' "

The committee also recommends that the effect of the above by-law be limited to a period of ten years.

The Committee on Constitution and By-Laws also recommends that Chapter 12, Section 4, of the By-Laws be amended to read as follows:

Add to Section 4 the following: "And provided further that this Association shall not be liable for attorneys' fees in such suits unless this Committee shall have first agreed in each case with the physician sued and the attorneys representing him in regard to the terms of such employment, including the fees to be paid."

Substitute for Section 7 the following:

"This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these By-Laws."

On motion of Dr. Good, duly seconded, the above report was adopted.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS

Secretary's Report: Your Reference Committee on Reports of Officers desires to report that they have made a careful study of the Report of the Executive Secretary, and desire to commend his work and move the adoption of his report.

Report of Treasurer: Your Reference Committee on Reports of Officers desires to report that they have made a careful study of the Treasurer's Report and wish to commend the treasurer on the excellent manner of making his report. The comparative tabulation of his report is unique and helpful. We move the adoption of his report.

Report of Chairman of Council: Your Reference Committee on Reports of Officers desires to report that it has made a careful analysis of the Report of the Chairman of the Council, as well as the Reports of the Councilor Districts, and we wish to commend the chairman and his committees for the excellent work they have done during the past year. We move the adoption of the chairman's report.

Report of Executive Committee: Your Reference Committee on the Reports of Officers desires to report that it has gone over the report of the Executive Committee and wish most heartily to commend the committee upon the character of work done during the past year.

Especially are they to be commended upon joining the Indianapolis Better Business Bureau, as outlined in their report.

In addition we wish to emphasize their recommendation to amend the Medical Defense By-Laws. We move the adoption of their report.

T. W. OBERLIN, Chairman.

(The above motions were duly seconded and unanimously carried.)

REFERENCE COMMITTEE ON NECROLOGY

WHEREAS, The Great Giver of all Good has so suddenly removed from our midst our dear friend and able and distinguished physician and surgeon, Thomas C. Kennedy, of Indianapolis;

BE IT RESOLVED by the Indiana State Medical Association, that we have lost a member who as President gave of his time and money to promote the welfare and growth of our society, a pioneer in one of its branches that placed his name among the benefactors of humanity.

BE IT FURTHER RESOLVED, that we express to his widow and daughter our deepest sympathy in their great loss of one so honored, and that a copy of these resolutions be sent to the bereaved family, and also spread upon the minutes of this meeting as a tribute to his life and work.

C. H. GOOD,
W. R. DAVIDSON,
C. N. COMBS,
Committee.

During the past year there has been taken from the thinning ranks of living ex-presidents one of its most highly esteemed members, Dr. John H. Oliver.

Dr. Oliver was loved and respected by hundreds of physicians who passed under his influence while students in the Indiana University School of Medicine.

Throughout his career Dr. Oliver was a member of the faculty, and few if any surpassed him in the ability to impress upon others high professional ideals and sound surgical wisdom.

His service to the Indiana State Medical Association, not alone during the year of his presidency, his illuminating counsel, his warm and generous personality, are now cherished memories, and we desire to record on our pages this inadequate testimony to his lifetime devotion to our organization.

C. H. GOOD,
W. R. DAVIDSON,
C. N. COMBS,
Committee.

On motion of Dr. Good, duly seconded, the above report was adopted.

At this time the retiring president, Dr. George R. Daniels, presented the incoming president, Dr. Charles E. Gillespie.

DR. CHARLES E. GILLESPIE: I have nothing to say except to promise you that I will devote a good deal of time and energy during the next year to the furtherance of organized medicine. I will be glad to see you all at Evansville next year.

DR. GEORGE R. DANIELS: I once heard an attorney say, in speaking of his client, that the most that could be said of him was that he never did anybody any harm. I hope you will take that as applying to your retiring president.

I wish to thank all of you, because all of you have been helpful to me. It has been a very pleasant experience and I am under deep obligations to you.

No further business appearing, the House of Delegates adjourned *sine die*.

THOMAS A. HENDRICKS,
Executive Secretary.

THE COUNCIL

GARY SESSION, SEPTEMBER, 1928

FIRST MEETING

The Council convened at 11:15 a. m. Wednesday, September 26, 1928, in Room 317, Hotel Gary, Gary, Indiana, for a luncheon meeting.

In the absence of the chairman the meeting was called

to order by George R. Daniels, president of the Association, and the roll-call showed the following present: George R. Daniels, president; Chas. E. Gillespie, president-elect; Albert E. Bulson, editor of THE JOURNAL; G. D. Scott, Sullivan; Walter Leach, New Albany; H. P. Graessle, Seymour; Jos. H. Weinstein, Terre Haute; E. C. Denny, Milton; E. E. Padgett, Indianapolis; M. A. Austin, Anderson; F. S. Crockett, Lafayette; E. E. Evans, Gary; Ira E. Perry, North Manchester; H. O. Bruggeman, Fort Wayne; Thomas A. Hendricks, executive secretary.

Every district was represented except the First and Thirteenth districts.

The minutes of the mid-winter meeting of the Council, held December 16, 1927, at the Indianapolis Athletic Club, Indianapolis, were approved.

As each councilor had made a short, informal report upon his own district in the September number of THE JOURNAL, and as there were no further comments, additions or changes to these reports, they stood as originally printed.

The preliminary financial report upon technical exhibits showed that there were twenty-six exhibitors, including *Hygeia,* occupying twenty-seven booths.

A scientific exhibit also was added to this year's scientific program.

Following a discussion, Dr. Bruggeman made a motion that THE JOURNAL shall not publish any professional cards that are misleading, and commending the attitude of the editor of THE JOURNAL in his stand in receiving only those professional cards that are ethical and in good taste. Motion seconded by Dr. Evans and carried.

Special committee composed of Councilors Crockett, Evans, Perry and Hall recommended that White County be placed in the Ninth District. Recommendation ratified by the Council.

A motion was made by Dr. Crockett that the Budget Committee meet at its discretion at a sufficient time ahead of the Council meeting to prepare a report for the Council's ratification at the mid-winter meeting. Carried.

Question discussed as to whether or not the Association should continue membership in the Better Business Bureau of Indianapolis. Upon the motion of Dr. Crockett this question was referred to the Executive Committee, which is to study and make recommendation at the mid-winter meeting of the Council. Carried.

The following request for a joint meeting between the Council and the members of the State Board of Health was received:

"July 12, 1928.—At the regular meeting of the State Board of Health today we discussed some matters pertaining to closer relationship and a better understanding between the State Medical Association and the State Health Department. I believe, as I am sure you do also, that some of the difficulties we encounter from time to time are the result of a lack of knowledge and understanding because of which we reach conclusions that are not justified in fact. The Board was of the opinion that a get-together meeting and conference would be helpful, and by resolution instructed me as secretary to ask for a joint meeting of the Council of the State Medical Association with the State Board of Health. I suggested that since the Council probably would have a regular meeting soon it might be possible to arrange for the conference at that time. On the other hand, if there should not be time for a conference of this sort at the regular meeting of the Council, it might be possible to have a special meeting for this purpose alone. The State Board of Health can be called in special meeting at any time that will best suit the convenience of the Council.

"Carrying out the resolution of the Board I am submitting this as an official request from the State Board of Health for a conference with the Council of the State Medical Association at a time most convenient to the Council for the purpose of discussing together any and all matters of mutual understanding.

"WM. F. KING, Secretary."

It was the consensus of opinion of the Council that the time for such meeting be set for the mid-winter meeting of the Council.

Dr. Crockett was instructed to prepare a resolution to be presented at the next meeting of the Council upon the advisability of creating a contact committee to cooperate with proper government officials in any activity of legitimate concern to the medical profession.

There being no further business the meeting was adjourned. THOMAS A. HENDRICKS,
Executive Secretary.

THE COUNCIL

GARY SESSION, SEPTEMBER, 1928

SECOND MEETING

The second meeting of the Council was held directly following the breakfast meeting of the House of Delegates at 9:45 a. m. Friday, September 28, in the rooms of the Commercial Club, Hotel Gary, Gary, Indiana.

In the absence of Dr. Wm. R. Davidson, chairman, Dr. George R. Daniels called the meeting to order. The roll-call showed the following members present: George R. Daniels, president; Chas. E. Gillespie, president-elect; Second District, G. D. Scott, Sullivan; Fourth District, H. P. Graessle, Seymour; Fifth District, Jos. H. Weinstein, Terre Haute; Sixth District, E. C. Denny, Milton; Seventh District, E. E. Padgett, Indianapolis; Eighth District, M. A. Austin, Anderson; Ninth District, F. S. Crockett, Lafayette; Tenth District, E. E. Evans, Gary; Thirteenth District, H. M. Hall, Newcastle; Thomas A. Hendricks, executive secretary.

As Dr. Davidson resigned as councilor for the First District, and as chairman of the Council, Dr. Evans, councilor of the Tenth District, was elected temporary chairman of the Council to serve until the regular mid-winter meeting in December.

In accordance with the instructions received at the first Council meeting, Dr. Crockett presented the following resolution:

"I move that the chairman of the Council appoint a temporary committee to report back to the mid-winter meeting of the Council concerning the advisability of the creation of a permanent contact committee whose duty it will be to inform and cooperate with proper government officials whenever vacancies occur on boards or commissions engaged in any activity of legitimate concern to the medical profession, who will be known to these government officials as the committee to which they may apply whenever they desire to know the attitude of the medical profession."

Resolution adopted, and Dr. Evans, chairman, said that he would appoint in the near future a temporary committee to study this question.

The Council selected Thursday, December 20, as the time for the mid-winter meeting, the place and hour to be set by the executive secretary. The executive secretary was instructed to invite the entire Committee on Public Policy and Legislation to attend the meeting at that time.

A vote of thanks was given to Dr. Davidson, retiring chairman of the Council, for his splendid work and activity in behalf of scientific medical organization while a member and chairman of the Council.

There being no further business the meeting was adjourned. THOMAS A. HENDRICKS,
Executive Secretary.

SCIENTIFIC MEETINGS

GARY SESSION, SEPTEMBER, 1928

MINUTES

The first general meeting of the Gary session, 1928, of the Indiana State Medical Association, was held in the ball room of the Hotel Gary, convening at nine-thirty on the morning of Thursday, September 27, 1928, with

the president, Dr. George R. Daniels, of Marion, in the chair.

THE PRESIDENT: At this time it gives me great pleasure to present to you Dr. H. C. Parker, of Gary, who will introduce the mayor of the city.

DR. H. C. PARKER: Mr. President, Members of the Indiana State Medical Association, and Guests: This is indeed a glorious occasion for the Lake County Medical Society. For years our members have been traveling all over the state, visiting various cities and accepting their hospitality. Today you are here as our guests, and we shall endeavor to provide you with entertainment, give you a good program, and we hope you will go away happy.

While this session is held in Gary, we want to remind you that the whole of Lake County is your host. The entire membership, together with the wives of the doctors, are banded together in one large reception committee, each member of which wears a badge with the words, "Your Hosts." If we can do anything to assist you at any time, call upon us and we will respond. We are glad you are here, we want to make your stay pleasant and profitable, and we hope you will come again.

I now want to present to you the youngest mayor of this young city, Floyd E. Williams, who will extend the official welcome of the City of Gary.

ADDRESS OF WELCOME

FLOYD E. WILLIAMS, Mayor of the City of Gary: Mr. President, Members of the Indiana State Medical Association, and Guests: I assure you that the City of Gary is highly honored in being privileged to entertain you as guests of our local organizations. I have been privileged to know the physicians of this city in an intimate way for the past ten or twelve years, and I assure you it affords me personal pleasure to be able to assist them in this undertaking.

We are very proud of Gary and its achievements. You must realize in going over the city that Gary is only twenty-two years old. As you know, twenty-two years ago Gary was known as the shores of Lake Michigan—the site of this hotel was a big swamp where we used to hunt ducks in my boyhood days. Today we are a city of 110,000, with an assessed value of practically $17,000,000. We have schools that are educating from 25,000 to 27,000 children, composed of all the nationalities known to men. We have some forty-two different nationalities represented in Gary; we have thirteen or fourteen different denominations in churches; we have four very fine hospitals that are rendering service to humanity. We have five or six hundred acres of parks that have been developed in the past six or seven years, and I am sure that the physicians who are contemplating your entertainment will show you all of these things.

We want you to have a good time while you are here; we want you to feel at home, and we know that when you leave here you will go back to your respective homes with a favorable impression of Gary that will place it on the plane it justly deserves.

I am reminded of a story of a gentleman traveling between Chicago and New York who was reading a Bible on the train. Across the aisle sat a man whose curiosity finally got the best of him and he asked, "What is that book you are reading?" "That is the Bible." "Oh! Well, I don't believe that book." The man read on and did not say anything. Again the man across the aisle said, "I don't believe in that book." Still the man read on and made no response. For the third time the other man said, "I guess you did not hear me. I do not believe that book you are reading." Then the man who was reading turned and said, "Pardon me, my friend; if you must go to hell, please do so quietly."

So if you must have a good time while you are here, be as quiet as you can, but if you get into jail and these Gary physicians cannot take care of you, I will.

At this time the president-elect, Dr. Charles E. Gillespie, introduced the president, Dr. George R. Daniels, who read the President's Address. (Reproduced in another department of THE JOURNAL.)

The Scientific Program followed. Dr. O. T. Scamahorn, of Pittsboro, chairman of the Section on Medicine, presiding.

Dr. William H. Ordway, assistant medical director Metropolitan Life Insurance Company, Mount McGregor, New York, read a paper entitled "A Laboratory Diagnosis of Tuberculosis." This was discussed by Dr. Eric A. Crull, Fort Wayne; Henry Frederick Helmholz, Rochester, Minnesota; and the discussion closed by Dr. W. H. Ordway.

Dr. W. D. Little, Indianapolis, read a paper entitled "The Changing Conceptions of Exophthalmic and Adenomatous Goitre." This was discussed by Drs. Miles F. Porter, Sr., Fort Wayne; G. G. Eckhart, Marion; Goethe Link, Indianapolis; and the discussion closed by Dr. W. D. Little.

Dr. Henry Frederick Helmholz, professor of pediatrics, University of Michigan Medical School, read a paper entitled "Pediatrics: The Fevers of Childhood." This was discussed by Drs. Milo K. Miller, South Bend; Reuben A. Craig, Kokomo; and the discussion closed by Dr. Henry Frederick Helmholz.

Adjourned. THOMAS A. HENDRICKS, Executive Secretary.

The Thursday afternoon meeting convened at two-fifteen, Dr. Henry O. Bruggeman, chairman of the Surgical Section, presiding.

At this time the chairman introduced Dr. Arthur J. Cramp, director of the Bureau of Investigation, American Medical Association; and Dr. J. M. Dodson, executive secretary of the Bureau of Health and Public Instruction of the American Medical Association.

Dr. Palmer Findley, president of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Omaha, Nebraska, read a paper entitled "Puerperal Infection." This was discussed by Drs. A. M. Mendenhall, Indianapolis; E. E. Padgett, Indianapolis; Miles F. Porter, Sr., Fort Wayne; Maurice Buchsbaum, Gary; John F. Loomis, Marion; M. A. Austin, Anderson; Charles Stoltz, South Bend; Christopher M. Reyher, Gary; J. M. Dodson, Chicago; H. O. Bruggeman, Fort Wayne; and the discussion closed by Dr. Palmer Findley.

Dr. Otis B. Nesbit and Dr. Margaret G. Smythe, Gary, presented a paper entitled "Health Work in the Gary Public Schools." This was discussed by Drs. John E. Yarling, Peru; John C. Burkel, Lafayette; and the discussion closed by Dr. Otis B. Nesbit.

Dr. Edward Francis, United States Public Health Service, presented a paper on "Tularaemia and Undulant Fever." This was discussed by Drs. William F. Shumaker, Butler; Alfred S. Giordano, South Bend; Roscoe L. Sensenich, South Bend; and the discussion closed by Dr. Edward Francis.

Dr. Albert Keidel, associate professor of clinical medicine, Johns Hopkins University School of Medicine, Baltimore, read a paper entitled "The Treatment of Syphilis." This was discussed by Drs. Louis J. Wisch, Whiting; John H. Gilpin, Fort Wayne; and the discussion closed by Dr. Albert Keidel.

Adjourned. THOMAS A. HENDRICKS. Executive Secretary.

THE BANQUET

The annual banquet of the Indiana State Medical Association was held in the ball room of the Hotel Gary, Thursday evening, September 27th, Dr. Thomas W. Oberlin, of Hammond, acting as toastmaster.

DR. THOMAS W. OBERLIN: As I look up and down this table I see the faces of men who in past years have served this Association in the capacity of president—men elected because of their ability in the medical field. During the past year the Executive Committee of this Association concluded it would be a good plan to confer

upon these gentlemen an honorary degree, a diploma, an award of merit, and they decided that at this banquet this award should be made.

It hardly seems possible that a man of my youth should be called upon to distribute these diplomas, so I have decided to ask one of the gentlemen who long has been associated with the Indiana State Medical Association, a man whose ability to handle the king's English is well known over the entire medical state, a man who is able even to keep Shanklin quiet—who tells him when to talk and he talks—a man who can present these diplomas with the grace of a Chesterfield. I have the honor to present Dr. Albert E. Bulson, the editor of the Journal of the Indiana State Medical Association.

Dr. Albert E. Bulson: Ladies and Gentlemen: I have been admonished by the chairman of the Committee on Arrangements to be brief, and in view of the fact that only a few hours ago I was advised that I had been selected to make a few remarks in connection with the presentation of a testimonial to the living ex-presidents of the Association, I am forced to be brief for want of suitable preparation for a formal or lengthy address.

The Indiana State Medical Association has a record of notable achievement of which we are proud. Tonight, as a part of the program, we are honoring some of the living men, nearly all of whom are before you, who have had a conspicuous part in forming the policies and shaping the destiny of our Association. It is unfortunate that owing to illness or the infirmities of age, a few of those whom we desire to honor are not here, and yet to them as well as to those who are here we wish to express our feeling of deep appreciation of the part each has played in upholding the high ideals of our Association, as we also wish to testify to our debt to them for their constructive thought and effort which in such a large measure has resulted in the development of the present magnificent organization.

It is a tradition of this Association that to the men who have served, and served well, should be given the honors. So to these ex-presidents, each and every one of whom has been active in building the Association upon a sound foundation and upholding the highest professional ideals, has at some time in the past been awarded the presidency, the highest honor in the gift of the Association.

Time does not permit me to mention each one of our living ex-presidents and refer to his activities in connection with the history of our Association, even though I have known each one of them rather intimately. However, I do desire to mention Dr. George F. Beasley, of Lafayette, who was president of our Association thirty-five years ago, and who now at the age of eighty-eight years still is actively engaged in the practice of medicine, and until this year has been a regular attendant at the annual sessions and taken an active part in the Association's deliberations. Only a few weeks ago he submitted for publication in The Journal a paper on a surgical subject in which he expressed in a clear and logical manner his conclusions as based upon wide experience.

I also desire to mention Dr. William N. Wishard, of Indianapolis, who was president thirty years ago, and who throughout his entire medical career, even including the present moment, has been active in all the affairs of our Association. For more than forty years there has been no constructive work in medical education, medical legislation, and in shaping the policies of our Association that have not borne his imprint, and today, with the exception of our executive secretary, there is no one who is doing more work for our Association as regards time and accomplishment than he.

I could go on down the list, including Dr. M. F. Porter, of Fort Wayne, who for over forty years has taken an active part in every session of our Association, and who was honored by being elected for nine years' service as trustee of the American Medical Association; to Dr. C. N. Combs, of Terre Haute, who served so efficiently as secretary for so many years, and whose constructive work is more and more appreciated as time goes on; to Dr. W. R. Davidson, of Evansville, who has been a tower of strength as chairman of the Council for many years; and to Dr. E. M. Shanklin, of Hammond, active in all constructive efforts in behalf of the Association, and whose work at this session speaks for itself. Each and every one of our ex-presidents had a guiding hand in the activities and destinies of this Association, and his work and influence has not been confined to pre-election periods.

It has been said that those deserving honor should be honored during life, and while some may say that these men were honored when elected to the highest gift in our Association, yet we know that office was not the goal for which they worked, for they have continued to serve our Association up to and including the present time. It is largely through their wise counsel, past and present, and their insistence upon carrying out the highest ideals of our profession that our Association has reached its present eminence.

It is entirely fitting that we should bear testimony to our appreciation of their service as well as their professional standing, and, therefore, we have prepared a certificate to commemorate their services and as an evidence of our appreciation.

I shall call upon those present in the order in which they served, and ask each to arise for presentation to this audience, and to receive the certificate.

Charles S. Bond, Richmond	1894
Miles F. Porter, Fort Wayne	1895
William N. Wishard, Indianapolis	1897
John C. Sexton, Rushville	1898
John B. Berteling, South Bend	1902
Charles H. McCully, Logansport	1919
David Ross, Indianapolis	1920
William R. Davidson, Evansville	1921
Charles H. Good, Huntington	1922
Eldridge M. Shanklin, Hammond	1924
Charles N. Combs, Terre Haute	1925

The past presidents who are living but unable to attend, and for whom certificates have been prepared, are:

George F. Beasley, Lafayette	1892
George W. McCaskey, Fort Wayne	1900
George T. McCoy, Columbus	1904
William F. Howat, Hammond	1911
Joseph R. Eastman, Indianapolis	1917
William H. Stemm, North Vernon	1918
Samuel E. Earp, Indianapolis	1923
Frank W. Cregor, Indianapolis	1926

The Toastmaster: Before introducing the principal speaker of the evening I would like to say a word or two on my own behalf. I presume you have been welcomed and rewelcomed, but I want to say, personally, that I am glad you are here. The only complaint I have is that you did not come soon enough.

We who live up here in the northern end of the state, where kidnapping, murders, blackmail, and various kinds of confidence games are an everyday occurrence, felt that perhaps you folks from down in the state might be a little timid about coming up here, and therefore more timid still about going to Chicago. So the Committee on Program thought it would be wise to have someone who was acquainted with the skin game, known among physicians as dermatology, come and instruct you somewhat in the ways of the world, and of Chicago in particular.

The man whom I am about to introduce has a national reputation in dermatology and other things medical; he has written many text-books which are standard; he is an authority on medical economics; and in addition to that he has been honored by having served for nine years as treasurer of the American Medical Association, and I can tell you, on the authority of Dr. Bulson, that his bondsmen were never called upon to make good. Later he was made president of the American Medical Association, an honor to which many aspire but few attain.

I have the very great pleasure of presenting at this time Dr. W. A. Pusey, of Chicago, who will talk to us upon "The Worldly Rewards of Medicine."

DR. WILLIAM ALLEN PUSEY, Chicago: Mr. Toastmaster, Ladies and Gentlemen: I am glad I was sitting where my face could not be seen during that introduction, on account of my resentful feeling over the first part of it, and my appreciative feeling over the second part. Although I have not a spontaneous thought in my head right now, I am reminded of the story of the little boy whose grandmother sent him a pincushion. His mother told him he must write grandmother and thank her, so he wrote: "Dear Grandmother: I am so much obliged to you for the pincushion. I always wanted a pincushion —but not much."

That is the way I feel about the first part of the introduction referring to our town, which is actually one of the quietest and most God-fearing communities in this country, but slandered by the rest of the world, and surprisingly so by our neighbors around here whom we love so much.

I am very glad to be here. I am always glad to be with the Indiana State Medical Association on any occasion, but I am particularly glad to be here tonight, for two reasons: First, to be present at the presentation of these diplomas of merit to the ex-presidents of the Association. I am getting old enough to like to see elderly men honored. I have read a poem somewhere that expresses my sentiments on this occasion, to the effect that if you have a word of praise for a man, give it to him now, "For he cannot read his tombstone when he's dead."

But if the truth be told I am especially glad to be here because the ladies are here. I like the bright lights, and I like Nature, too. I enjoy the beauty of the dunes, with the deep shadows and glistening sunlight, the shifting sands, and the ripple of waves on the beach; but I like to hear the band play, too, and as far as I am concerned the band always plays when the ladies are around. I think medical meetings for men only are pretty drab, dull affairs, but when the ladies attend we have some real fun. They give warmth and color, laughter and sweetness, to a meeting. I do not believe you ladies appreciate how much we think of you. You are the inspiration of all our labors. Nearly all we are in the world we owe to you—and the rest we owe for you, so just let us make it one hundred percent. But seriously, I like to see the doctors' wives around. You undertook a pretty hard job when you married us. We are irregular in our hours; you make an engagement and we cannot keep it, and you cannot tell whether we are lying or not. You carry a big load, and I take the liberty of speaking for the entire Indiana State Medical Association when I say that we are glad you are here. That is not my function, but I just like to say it.

My topic this evening is "The Worldly Rewards of Medicine." We of the medical profession are so constantly lecturing each other, and having it driven home at our meetings that our most important duty is to our fellowmen, that I thought it worth while to reverse the subject this evening and consider our duty to ourselves and our families. Heaven forbid that I should give the impression that I would do anything to reduce our altruistic interests. They are the great source of satisfaction and stimulus of our calling. But there is a corollary to this, however. We have done our best to discharge our responsibility to others, and we have a right to ask ourselves, "How do we fare in this situation; what have we to expect, and what do we get out of it?"

I consider the subject with some pleasure because it is one in which I always have had an active interest. I shall not pretend to bring to it great wisdom, but I do claim to know something of the subject from experience. I have had the experience of a good deal over thirty years in as intimate contact as possible with the profession of a great city—daily contact with the rank and file of both city and country. I have, it is true, been seeing medicine in great part from the standpoint of the specialist, but I believe I am still actually at heart an old country doctor. I have not had any experience as a country doctor for more than thirty-five years, but I have known the country doctor's life from the inside, thirty to forty years ago, when it was harder than it is now. The doctor's old saddlebags were as familiar to me as a motor car is today. From the time I was a young child until I was twenty-seven, when my mind was in its most plastic state, I made the rounds with a country doctor on every possible opportunity, and I got an impression of the country doctor's life that has been a satisfaction all my life. That sort of practice, however, has no sentimental glamour for me. I know its difficulties, its hard-earned material rewards, and yet the family doctor, even in the country, has a career which holds many of life's compensations. I hope you will not hastily judge that I am one of those sentimentalists about the country doctor who knows nothing of the hardship of getting the horse and buggy in the middle of a cold night and driving ten miles over bad roads to make an unnecessary visit. That is not the case.

Thirty years ago I was asked to speak on the subject of "The Social Position of the Medical Profession" at an alumni banquet of the old medical school where I was a young dean. On that occasion I did not live up to my responsibilities. I was supposed to talk about our grievances. I did not know we had any—at least, not more than other people. It always seemed to me a good life, and I took the position that we were luckier than most people, and that our social position was usually as good as we deserved, and often better. I took occasion to call attention to some of the notables in medicine and the social position they had held, from the time of Harvey down—Harvey, who was a rich man and physician to the king. Many others might be named, great personages as well as great physicians. In America we had Benjamin Rush, and a long line of great medical men who held the highest social position in their cities. I shall not undertake to add to this any names later than thirty years ago, but I venture to call attention to them again as illustrating the fact that great men in medicine may expect all the social recognition to which they are entitled. "But," I said, "that has nothing to do with the physician in our small towns and cities. How is he recognized?" I answered that question thirty years ago in this way: "The fact is that you and I, except where we have some defect of self-confidence, hold as good a place as we deserve. In the smaller cities and towns the physician is usually the first citizen, the first man in time of trouble, a friend in physical difficulties and in the most intimate domestic affairs; the one who is depended on in all serious physical emergencies. Such a man leads a life of solid satisfaction. His material prosperity is sufficient, his surroundings are pleasant, his sons and daughters go to college, and he himself has the inestimable satisfaction of knowing that he plays a large and useful part in his community, and that when he dies he leaves an irreparable gap—if any gap in life can be said to be irreparable."

That was the panegyric I delivered on the social position of the doctor in the primrose days of my youth. What have the hard knocks of thirty years done to these views? Truth to tell, they have not done anything. I am still willing to maintain, from experience and observation, that the world at large is inclined to accept us on the estimate I made that night. If I may paraphrase Sidney Smith's well-known remarks on the strawberry, "God Almighty might have made a better man than a good doctor, but He never did."

Now I have no delusions that the life of the doctor is all cakes and ale; we all know that we get some beer and skittles. But I am firmly of the opinion that with the exception of the occasional injustices which are a part of life, we have on the whole an enviable position in our social condition and our influence. The individual

physician who is entitled to it is likely to have greater influence in his community than another man of equal merit. He does not have as much influence collectively as he should, but that is because he does not work, as a rule, collectively; he is used to being independent and does not work in organizations. The answer to that is that he should belong to his medical society and the medical society should be active in matters of public interest.

Now what about our economic status? How do we manage the "imperious necessity of making a living?" The subject is very interesting and is in the back of the heads of all of us a good deal of the time in one form or another, and not lacking in our informal discussions. I am impelled to believe, therefore, that it is a topic of interest to all of us. How do we rank in the community, considering what we have a right to expect, in making a living? I believe—and I fear I am a heretic on this subject—that on the whole the larger proportion of us make a more comfortable living than do most men of the same social order. Taking us as a group it has long seemed to me that the average doctor has about his share, when it comes to a comfortable living. It is not riches, and no more is it starvation. He usually follows the scriptural idea of "neither poverty nor riches." He and his family have their share of advantages. We are prone to deny this fact, but if you compare the doctors generally with men of equal capacity and opportunity in other walks of life, I think you cannot deny that they are as well off on an average as any of them.

We are notoriously regarded as being poor business men. Of course in a technical sense we are not trained for business. We are not familiar with the business man's methods and ways of making money. The fact is that most men are not good business men outside of their own vocation. We are all on the "sucker" list, along with bankers and railroad presidents, successful merchants and manufacturers, lawyers and preachers, and the list is usually active. Everyone of them, so far as my experience goes, tries now and again to improve his fortunes by some sort of foolish speculation.

In our own proper sphere of business, which is charging properly for our services and collecting our charges, I do not know whether we are any worse than the business men in general would be if they were in the same situation, for we are in the situation of the merchant whose stock is consumed when he sells it. Our stock in trade is under our hats. The more we use of it the more we have in the way of experience, so we are apt to value it lightly—like the little French girl who did not mind wasting a kiss or two because she has just as many left. It is perhaps because of this that we are not as good business men as we should be in utilizing our time and charging for our services and collecting our fees.

The question of charges is always a troublesome one. I believe they should be made, first, upon the basis of the quality of our services, and, second, upon the extent and value of them. I believe that there are few physicians who do much in their profession who do not take care, as far as practical, of all deserving patients. It is a good principle to let the poor man pay according to his means, and in general I feel that our charges should be a fair amount that can be handled without crippling the patient. Such a policy being adopted, I am firmly of the opinion that men should pay for services rendered them to a considerable degree in proportion to their ability to pay. It is sometimes said that the value of health and life cannot be reckoned in dollars. That is true; but the value of services for health and life can be determined in terms of knowledge and what we have involved, and this should be taken into consideration in valuing the services rendered. The lawyer sees to it that he is paid in proportion to the value of services rendered; the banker, the architect, the manufacturer base their charges upon the same principle, and in those instances, and many others that could be mentioned, this practice goes unchallenged. Salvage is recovered according to the monetary value of the ship and cargo. We have the right to do the same sort of reckoning. It may be a burden for a poor man to pay the smallest fee for services, and it is unfair that he should be charged any more than a fraction of regular fees. On the other hand, it is preposterous that a rich man or woman who does not hesitate to spend thousands upon baubles like furs and motor cars, and expensive oil paintings, simply to satisfy their vanity, should not pay more than the price of a dress or a suit of clothes for medical services that are of more value to them than anything else material in this world. I know of no more unjust proposition than that established by several hospitals a few years ago, but who subsequently receded from their position, that no more than $200 or $300 should be charged for any medical service in those hospitals. Take a man who will pay $10,000 to $15,000 to have his portrait painted, and charge him $200 for carrying him through the greatest crisis of his life, is economic suicide and an outrage to medicine.

One justification which cannot be denied for charging a man who has much of this world's goods more than the poor man is that the favored man wants all the judgment and skill there is, and the more experience we have had the more of these qualities we can furnish. The more people we have treated, the more experience and skill we have for him. No one can acquire these qualities on the rich—there are not enough of them. We are not charging for the hour's work; we are charging for the work of a lifetime. The men who uphold the value of medical services are charging well for them when it is proper for them to do so, and they are a benefit to the profession provided they render good services, and this point I would like to emphasize.

When I speak of justification for our charges I assume that they represent skillful service. We have no right to charge for competent service when it is not rendered. I do not think people object to paying well for the physician's services, even if they result in failure, if they feel the services are good. They do object, however, and they have a right to do so, to paying any sort of charges for insufficient or unskillful services. It is up to us to deliver the value of our charges before we complain, and while we have every justification for asking the man of means to pay us for services in the same way he spends his money for the luxuries of life, that fact gives us no excuse for exorbitant charges to people who cannot afford to pay. The rule should work all the way round.

About collections I feel as I do about charges. The man who would pay but cannot should be treated with the utmost consideration; the man who can pay and will not should be made to do so. I feel we have a sort of moral responsibility on our part of preventing the rascals from getting the rewards of their rascality. It is a tradition that we are poor collectors, and I think most of us are so through lack of system. The greatest fault in this respect is that we are slow in presenting our bills, and reluctant to press them. Bills should be presented promptly, with due consideration for special circumstances and the means of the individual. One is entitled to collect for one's services promptly, and the patient is entitled to know promptly what he owes. If it is customary to send bills monthly, patients are not offended. As a matter of fact, I believe a lot of the so-called lack of appreciation of our services, and our carelessness in collecting, is due to timidity. We are afraid of offending people and think perhaps it is better to pursue the easier course. My experience is that there is nothing in that. I am very strongly of the opinion that there is nothing gained by trying to play the other man's game. Rather, the advantage lies in playing one's own game, and playing as well as one knows how.

In all that I have said I do not want to give the impression that we should give charity to the poor and rob the rich. We should not rob anybody. But I do mean that we should charge for our services in proportion to

their value in terms of the individual's material situation, not being afraid to charge the rich a good fee for good services. My conviction is that the doctor gets more than the ordinary man's share of gratitude of those he serves.

We may, therefore, say that the doctor is a useful member of his community; his social position is good enough to satisfy his wife and daughters, which is the highest standard anyone can hope to attain; his economic condition is sufficient to allow him to enjoy all of the advantages of his surroundings, and he may lead a life that is satisfying to the self-respect and ambition of both himself and his family. A man has a right to hope for no more.

Following Dr. Pusey's address he was given a rising vote of thanks for his presentation.

Adjourned.

THOMAS A. HENDRICKS,
Executive Secretary.

The Friday morning Scientific Program was presented following the meeting of the House of Delegates, Dr. B. D. Ravdin, of Evansville, secretary of the Section on Ophthalmology and Otolaryngology, presiding.

The following symposium on "Diabetes" was presented:

"Diabetes from the Standpoint of the Otolaryngologist," Dr. Joseph C. Beck, Chicago.

"Diabetes from the Standpoint of the Ophthalmologist," Dr. Harry S. Gradle, Chicago.

"Diabetes from the Standpoint of the Internist," Dr. Solomon Strouse, associate professor of medicine, Northwestern University Medical School.

This symposium was discussed by Drs. Roscoe Hamilton Beeson, Muncie; M. Ravdin, Evansville; C. P. Clark, Indianapolis; Maurice Buchsbaum, Gary; and in closing by Drs. Joseph C. Beck, Harry S. Gradle, and Solomon Strouse.

The election of officers for the sections was announced as follows:

SECTION OFFICERS
1929

Section on Surgery:
Chairman—Ernest Rupel.....Indianapolis
Vice-Chairman—William C. Moore.....Muncie
Secretary—Cleon A. Nafe.....Indianapolis

Section on Medicine:
Chairman—Roscoe H. Beeson.....Muncie
Vice-Chairman—Samuel C. Waters.....Middletown
Secretary—Harvey L. Murdock.....Fort Wayne

Section on Ophthalmology and Otolaryngology:
Chairman—Henry C. Knapp.....Huntingburg
Vice-Chairman—F. V. Overman.....Indianapolis
Secretary—B. D. Ravdin.....Evansville

This finished the Scientific Program, and the Indiana State Medical Association adjourned *sine die*.

THOMAS A. HENDRICKS,
Executive Secretary.

THE WOMAN'S AUXILIARY

INDIANA STATE MEDICAL ASSOCIATION
GARY SESSION, SEPTEMBER, 1928

The first meeting of the Woman's Auxiliary to the Indiana State Medical Association was held on Wednesday afternoon, September 26th, in Hotel Gary, Gary, Indiana, with about one hundred women present. After the call to order by the president, Mrs. F. W. Cregor, Indianapolis, the Constitution prepared at the Executive Board meeting in May was read and adopted.

Reports were given by the president, Mrs. F. W. Cregor, Indianapolis; by the secretary, Mrs. A. C. Clauser, Delphi; by the treasurer, Mrs. O. T. Scamahorn, Pittsboro; by the president of the Madison County Auxiliary, Mrs. M. A. Austin, Anderson; by the president of the Carroll County Auxiliary, Mrs. A. C. Clauser, Delphi; by Mrs. Homer G. Harmer, of the Indianapolis Auxiliary; and by Mrs. E. T. Zaring, Terre Haute, of the Vigo County Auxiliary. No report from the Delaware County Auxiliary.

Mrs. Ora Lee McKay, Rommey, reported interest in the Ninth District. Mrs. W. R. Davidson, Evansville, president-elect, taking office January 1, 1929, greeted the ladies, convincing them of her abilities for leadership. Inspirational talks were given by the guests of honor, Mrs. Morris Fishbein, of Chicago, wife of Dr. Morris Fishbein, editor of the *Journal of the A. M. A.*, and Mrs. G. Henry Mundt, Chicago, president of the Woman's Auxiliary to the Illinois State Medical Association. Both of these guests stressed the possibilities for pleasure and helpfulness awaiting physicians' wives united in the auxiliary.

The Nominating Committee presented the names of Mrs. M. A. Austin, Anderson, for president-elect (taking office January 1, 1930); Mrs. Edgar Kiser, Indianapolis, for secretary, and Mrs. E. T. Zaring, Terre Haute, for treasurer. The report was accepted unanimously. Other officers to be Councilors from the thirteen districts, as is the plan in the Indiana State Medical Association.

Mrs. F. W. Cregor read a letter written by Dr. George R. Daniels, Marion, president of the Indiana State Medical Association, offering best wishes and promises of assistance.

Following several announcements the meeting was adjourned. The short time Mrs. Cregor could remain in Gary she was impressed by the friendliness of all, one of the purposes of the auxiliary being "to promote acquaintanceship among physicians' families that closer fellowship may exist."

Dr. E. E. Padgett, Indianapolis, Councilor of the Seventh District, has invited Mrs. Cregor to plan the organization of an auxiliary to the Seventh District Medical Association, during the meeting at Martinsville, October 13th. Ladies from this district and nearby counties are urged to attend. It is most gratifying to have the physicians take the initiative in organizing an auxiliary, for after all our success depends upon the interest and co-operation of our husbands.

Respectfully submitted,
MRS. FRANK W. CREGOR,
President.

BUREAU OF PUBLICITY

August 27, 1928.

Meeting called to order at 2:30 p. m.

Present: Wm. N. Wishard, M.D., Chairman; M. N. Hadley, M. D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held August 20 read, corrected and approved.

The article, Preparation of Children for School—was reviewed and passed for release on Saturday, September 1.

The final draft of the annual report of the Bureau was presented to the committee. This draft was corrected and approved to be sent to the editor of THE JOURNAL for publication.

Letter and pamphlets received from the American Heart Association. The secretary was instructed to keep the pamphlets as they perhaps would supply material for the release at some future date.

The following letter was received from the executive secretary of the Bureau of Health and Public Instruction of the Amreican Medical Association:

"Thank you very much for your prompt reply to our letter about questionnaires we are planning to send out.

"If we can only get part of the states to take up the work of the health education of the public as vigorously and effectively as you have done in Indiana, I should feel very well satisfied with our campaign."

Report made upon the following medical meeting:

August 21, Kiwanis Club, Bedford, Indiana, "The Business Man's Heart."

The following radio talk was broadcast over station WFBM, Saturday, August 25—"Protection Against Typhoid Fever."

The following bills were approved for payment:

W. K. Stewart Company	$1.30
J. H. P. Gauss, M.D.	.50
Karl M. Koons, M.D.	3.68
	$5.48

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole September 10, 1928.

William N. Wishard, M.D.
Chairman
Thos. A. Hendricks,
Secretary

BUREAU OF PUBLICITY

September 10, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; M. N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held August 27th read and approved.

The following articles were prepared for release upon the seventy-ninth annual meeting of the Association to be held at Gary, September 26, 27 and 28:

Article for release to afternoon papers, Saturday, September 15.

Article for release to morning papers, Monday, September 17.

Report was made of the following medical meeting:

August 27—Teachers' Institute, Fowler, Indiana: "Immunization."

Request made for speaker at the following meeting:

October or November—Teachers' Institute, Fowler, Indiana: "Diphtheria."

The chairman of the bureau reported that on a trip to Canada he noticed in the *Manitoba Free Press* of Winnipeg an article similar to the publicity releases. This article was on "the nature, cause, and method of transmission of infantile paralysis" and was prepared by "the committee of city's medical society which was recently appointed to act in an advisory capacity in connection with the epidemic of the illness at present gripping Winnipeg."

A letter was received from the American Heart Association saying that future issues of the Bulletin of that organization would be sent from time to time to the Bureau.

A report was made by the executive secretary of a meeting held by the Physical Directors' Society at the Indiana Central College September 5tht where arrangements were made for Y. M. C. A. health weeks in the various cities in the state. On behalf of the Bureau of Publicity of the State Association the suggestion was made that in each city where the health weeks are to be held the cooperation of the local medical society should be obtained and that no individual physician's name but that of the local medical organization should be used in furthering health week. The physical directors were also warned that they should guard against any advertising or unethical physicians using these health weeks to further their own individual selfish interests.

The following bills were approved for payment:

Central Press Clipping Service	$ 5.00
Thurman B. Rice, M.D.	15.85
	$20.85

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole September 17, 1928.

William N. Wishard, M.D.,
Chairman.
Thos. A. Hendricks,
Secretary.

VANDERBURGH COUNTY MEDICAL SOCIETY

The regular monthly meeting of the Vanderburgh County Medical Society was held at the Evansville Public Health Center, Tuesday, September 11, at 8.15 p. m.

A pediatrics clinic was conducted by Dr. E. L. Boyd. A number of interesting cases were presented by Drs. Raphael, Muelchi, and Boyd. Dr. Adeline F. Muelchi presented a case of sporadic cretinism which has been under specific therapy for the past two years. This patient was presented by Dr. Muelchi two years ago and the improvement in the mentality and physical well-being is remarkable. Dr. I. J. Raphael presented two cases of idiopathic epilepsy which responded very favorably under a ketogenic diet. The society was quite favorably impressed with the results obtained. Dr. E. L. Boyd presented a case of idiopathic hemorrhagic purpura which required a number of blood transfusions before it was possible to check the hemorrhages.

Dr. Miller of the U. S. Marine Hospital was to have presented a case of pellagra before the society; the patient, however, was so weak that it was impossible to present him. Dr. Miller gave an excellent talk on pellagra in general. While being stationed in the southern states, Dr. Miller had the opportunity to have a large number of pellagra cases under his care.

A general discussion of the cases presented followed.

Respectfully submitted,
Keith T. Meyer, M.D.,
Secretary.

CORRESPONDENCE

UNETHICAL MEDICAL ADVERTISING AND OTHER IMPROPERTIES

Dubuque, Iowa,
September 13, 1928.

Editor The Journal:

In reply to your letter received today:

The expulsion of the members was due to unethical advertising of a "Clinic" group and consultation of members with this group since their expulsion. The last three were expelled at our last regular meeting two nights ago by a vote of 26 to 0. Not even a single vote of all the factions to accept their resignations which they tendered a month ago! Our total membership is about 55 for the county—45 in Dubuque.

The trouble started three years ago when three of our members started a group, supported by one of our hospitals, with much details in the newspapers concerning buildings, qualifications of men, etc. Then two years ago, with the arrival of a surgeon and two nurses from the Mayo Clinic, much ado was made about them in the newspapers. A copy of a comprehensive, laudatory article about buildings, equipment, personnel, etc., later appeared in surrounding newspapers with "adv." and numbers indicating that the articles had been paid for. Our collection of these amounted to eight from as many different small town newspapers. Personal letters to old patients and wolf-gang methods of getting new patients from competitors were other offenses.

Two years ago unethical charges, in the form of eleven counts, were filed against the three members of this group, but they were let off with only a censure. Six months later the "Mayo Surgeon" applied for admission with a transfer card from Omstead county (Rochester), Minnesota, with consequent rejection. He made an appeal to the councilor of our district, who upheld us in a decision letter wherein he stated that the three members of our society in the group also should be expelled. A

year later when the "Mayo Surgeon" again was applying, the same Councilor reversed himself, as he said "in the interests of harmony" and advised his admission. Rejection by almost unanimous vote. An appeal to this last rejection was then taken to the Iowa State Medical Society meeting this last June where, after all witnesses, defendants and exhibits were heard and reviewed, a decision similar to the Councilor's a year before, was made in our favor and that "the County Society is the sole judge of its own members."

After the state meeting our three members turned in their resignations, but were expelled by a 25 to 1 vote. Then a month ago another three of our members (non-clinic) turned in their resignations after repeated co-operation with the rejected and expelled physicians, and declared plans of joining the "Clinic." As stated in the beginning, their resignations were not accepted, but expulsion given by a 26 to 0 vote two nights ago.

Naturally our fight has interested the community and sides are taken as in political parties. Rochester has broken the ice for this kind of practice which, at least here, makes the individual physician fight for his existence.

Hoping I've made things clear; if not, let me know, I am,

Very truly yours,
J. H. SCHRUP, M.D.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books received since September 1, 1928:

A TEXTBOOK OF SURGERY for Students and Physicians. By W. Wayne Babcock, A.M., M.D., F.A.C.S., Professor of Surgery in the Temple University; Surgeon to the Samaritan Hospital and to the American Hospital for Diseases of the Stomach, Philadelphia, etc. Cloth, 1367 pages, with 1041 illustrations. Price $10.00. W. B. Saunders Company, Philadelphia and London, 1928.

PRACTICAL SURGERY OF THE ABDOMEN. By George H. Juilly, M.D., chief surgeon to the French Hospital, San Francisco, California. Foreword by W. Wayne Babcock, M.D. 1275 pages with 1291 illustrations, some in colors. Two volumes. Cloth. Price $16.00. F. A. Davis Company, Philadelphia and London, 1928.

SURGICAL CLINICS OF NORTH AMERICA (Philadelphia number). Issued serially, one number every other month. Volume 8, number 4, August, 1928. 285 pages with 91 illustrations. Per clinic year, paper binding, $12.00; cloth, $16.00. W. B. Saunders Company, Philadelphia and London, 1928.

TEXTBOOK OF FRACTURES AND DISLOCATIONS. Covering Pathology, Diagnosis and Treatment. By Kellogg Speed, S.B., M.D., F.A.C.S., associate professor of clinical surgery, Rush Medical College of the University of Chicago. Second edition, enlarged and thoroughly revised. 952 pages, illustrated with 987 engravings. Cloth. Price $11.00. Lea & Febiger, Philadelphia, 1928.

PREVENTIVE MEDICINE. By Mark F. Boyd, M.D., C.P.H., member of regular field staff, International Health Division of Rockefeller Foundation; formerly professor of bacteriology and preventive medicine in the medical department of the University of Texas. Third edition, revised. Octavo volume of 475 pages with 151 illustrations. Cloth. Price $4.50. W. B. Saunders Company, Philadelphia and London, 1928.

INTRODUCTION TO EXPERIMENTAL PHARMACOLOGY. By Torald Sollmann, M.D., professor of pharmacology and materia medica at Western Reserve University, Cleveland, and Paul J. Hanzlik, M.D., professor of pharmacology at Stanford University, San Francisco, California. 321 pages, illustrated. Cloth. Price $4.25. W. B. Saunders Company, Philadelphia and London, 1928.

SURGICAL DIAGNOSIS IN TABULAR OUTLINE. For students and physicians. By Dr. A. J. Cemach, Vienna, Austria. Translated and with additions and notes by Edward L. Bortz, M.D., associate in medicine, the Lankenau Hospital, Philadelphia. Introductory note by John B. Deaver, M.D. 109 tabular forms and 129 plates, with 548 subjects, many in colors. Cloth. Price $12.00. F. A. Davis & Company, Philadelphia, 1928.

DISEASES OF INFANTS AND CHILDREN. By Henry Dwight Chapin, A.M., M.D., emeritus professor of medicine (diseases of children) at the New York Post Graduate Medical School and Hospital; and Lawrence Thomas Royster, M.D., professor of pediatrics and head of the pediatric department of the University of Virginia. Sixth revised edition. 675 pages. Illustrated. Cloth. Price $7.50. William Wood & Company, New York, 1928.

PRACTICAL MEDICAL DICTIONARY. By Thomas Lathrop Stedman, A.M., M.D., editor of "Twentieth Century Practice of Medicine," etc. Tenth revised edition. Illustrated. 1194 pages. Flexible binding. Price $7.50. William Wood & Company, New York, 1928.

DISEASES OF THE EAR, NOSE AND THROAT. By Wendell Christopher Phillips, M.D., ex-president American Medical Association. Seventh revised and enlarged edition. Illustrated with 615 halftone and other text engravings, many original, including thirty-seven full-page plates, some in colors. 922 pages. Cloth. Price $9.00. F. A. Davis Company, Philadelphia, 1928.

DISEASES OF THE THROAT, NOSE AND EAR. By Dan McKenzie, M.D., F.R.C.S.E., surgeon Central London Throat and Ear Hospital; otolaryngologist to the French Hospital, London, etc. Two volumes. Second edition. 677 pages. Illustrated. Cloth. Price $17.00. St. Louis: The C. V. Mosby Company, 1928.

This is the second edition of a work in two volumes by an eminent British authority. The subject matter is splendidly presented and elaborately illustrated. Particularly noticeable is the carefulness and attention to detail that has been exercised in all of the descriptions, a valuable feature overlooked by many American authors. The attention given to methods of diagnosis is especially valuable for the student as well as the practitioner of medicine.

We note that the work is decidedly British, and that the subjects discussed are viewed from the British standpoint. In fact there is scant recognition of any other viewpoint, and some of the brilliant work done by Americans, as well as some European otolaryngologists, apparently is not recognized or given the slightest consideration. However, in a measure this omission of recognition of work outside of England does not in the least detract from the value of the book, for it is an excellent thing for the medical men of the United States to supplement their viewpoints by a knowledge of what is being done abroad. We may differ in our methods of examination and in the decision as to therapeutic measures to be adopted, and yet we must recognize that no just criticism can be offered concerning methods that we know have produced the excellent results exhibited in many of the English clinics and the private practices of our English confreres. Their methods have withstood the test of time and are worthy of respect. Therefore, we urge every American physician interested in ear, nose and throat work to add this excellent and authoritative two-volume work to his library.

THE NOSE, THROAT AND EAR. By John F. Barnhill, M.D., F.A.C.S., Professor of Surgery of the Head and Neck, Indiana University School of Medicine, etc. 604 pages, with 452 illustrations, four in color. Cloth. Price $7.50. D. Appleton & Company, New York and London, 1928.

The author says that he has prepared the work chiefly for students and practitioners of medicine. He should be complimented for having done the work so well, for

he has carried out his aim to present the essential facts in brief form, to avoid theoretical and controversial discussion, and to omit discussion of practices not well established. While great advances have been made in the theory and practice of otolaryngology, yet the author of this work seems to have presented the latest accepted knowledge on the subject, and he has made his work more useful by giving credit to confreres where credit is due. His long experience in both private practice and teaching, together with a keen and critical analysis of the current literature, has made it possible for him to present a work that may be said to be up to date, even though of limited size. One of the features that we especially note is that there has been no waste of words, and yet with conciseness there has been no curtailment of comprehensiveness. The book is well illustrated, many of the illustrations being original, and the publisher's work has been well done. We have no hesitation in saying that we believe that this book will meet the purpose for which it was intended by the author.

Pocket Medical Formulary. By William Edward Fitch, M.D., late major Medical Corps, U. S. A.; formerly lecturer on surgery, Fordham University School of Medicine, etc. Fifth edition, revised and enlarged. 501 pages, with flexible binding. Price $3.00. F. A. Davis Company, Philadelphia, 1928.

This is a very valuable and handy little book that may be carried in the pocket. It contains a vast amount of valuable information adapted to the needs of the general practitioner, and is so condensed that it forms a ready reference work. The subject matter as compiled has been gleaned from the works and writings of medical men of wide research and wide experience. Many trustworthy prescriptions are presented, and much valuable information is included concerning therapy in general. The diseases are arranged in alphabetical order, and the prescriptions arranged under the disease for which prescribed.

ABSTRACTS

HEALTH SUPERVISION OF EXECUTIVES IN INDUSTRY

Halstead G. Murray, Framingham, Mass. (*Journal A. M. A.*, Sept. 1, 1928), points out that health supervision in industry must have the approval and support of the directors of the concern. The examinations should preferably be on a voluntary basis, and done, if possible, at the factory on factory time. From experience the men like the health examination, give their cooperation, follow advice given in regard to living habits and rules of hygiene, and correct a large percentage of minor and major physical defects. Most business men have no recreational exercise during the winter. An indirect result of these examinations is that facilities for exercise have been provided on company time. Men who travel have been protected against smallpox and typhoid. An attempt to cut down the number of colds has met with a moderate degree of success. Colds, naturally, are the most common ailment and are responsible for the greatest amount of lost time and discomfort. Adequate vacations and adjustment of hours must lead to better health and better thinking. Men returning to work after illness are seen by the factory physician first. Through these means it is felt that health supervision has shown enough worth-while results to justify its continuance.

PROLONGED INSULIN HYPOGLYCEMIA WITHOUT SYMPTOMS

In connection with some experiments on the corpuscle-plasma distribution as related to insulin shock, S. J. Maddock and Harry C. Trimble, Boston (*Journal A. M. A.*, Sept. 1, 1928), were particularly impressed by the length of time that hypoglycemia can exist before symptoms appear. Experimental evidence shows that, following insulin administration, the blood sugar of diabetic patients and depancreatized dogs may remain at levels of fifty mg. per hundred cubic centimeters or below for from one to six hours without symptoms. Such periods may or may not be followed by hyperglycemic reactions. They believe that this phenomenon, whose dangers are evident, is probably frequent in occurrence; that it usually is unrecognized, and that it may account for the difficulty so often encountered in regulating the administration of insulin. It is tempting to the authors to reason by analogy that if continued high blood sugar overstrains the pancreas, continued low blood sugar may over rest it.

RELATION BETWEEN BACTERIAL FLORA AND TRACHEO-BRONCHIAL FOREIGN BODIES

In a preliminary study based on one hundred cases, Carl J. Bucher, Philadelphia (*Journal A. M. A.*, Sept. 1, 1928), shows the relation between the bacterial flora and tracheobronchial foreign bodies. The streptococci were of most frequent occurrence. *Streptococcus hemolyticus* was less often isolated than *S: viridans* and the non-hemolytic types. Proportionately, they occurred more frequently when the foreign body was a vegetal or bony one. In almost all the cases in which they were present, the patients were acutely ill. These organisms were present in pus aspirated from children and from adults. The pneumococcus was obtained in 36 per cent. of all cases. It occurred in the young and the old, in patients who were acutely ill, and in those not so much affected. A limited number of the pneumococci were typed but not a sufficient number to warrant definite conclusions. It is, however, interesting that most of them thus far have been type 4; only one was a type 2 and two were type 3 pneumococci. Further studies along this line are in progress. While both *Staphylococcus aureus* and *albus* were frequently isolated in this series, they were not limited to any one type of case. Occasionally they occurred in pure culture. They were found in young and old persons and in mild and severe reactions to the foreign bodies, and the length of sojourn did not seem to influence their presence or absence. *Bacillus influenza* never occurred in pure culture. Usually it was associated with *Micrococcus catarrhalis* or *Micrococcus tetragenus*. Spirochetes were recovered only once, and in that particular case there was a coexisting putrid bronchitis. Yeasts occurred several times. As far as Bucher was able to determine, they were saprophytes. He concludes that a variety of pathogenic bacteria are present in the trachea and bronchi of foreign body cases. Many of these are capable of producing infection. There is usually more than one kind of bacteria present in the bronchus of a single case. In the great majority of cases the degree of infection seems to depend more on the type of foreign body, the degree of obstruction to drainage, the age of the patient and the sojourn of the foreign body in the bronchus than on the kind of bacteria present.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

Petrolagar (Unsweetened).—Liquid petrolatum 65 cc. emulsified with agar in a menstruum containing sodium benzoate 0.1 Gm., and water to make 100 cc. Deshell Laboratories, Inc., Chicago.

Mead's Standardized Cod Liver Oil, Flavored.—Mead's standardized cod liver oil (New Nonofficial Remedies, 1928, p. 253) containing 0.12 per cent of a mixture of vanillin and oil of lavender as flavoring. Mead Johnson & Co., Evansville, Ind.

Cellu Soy Bean Flour.—A partially defatted flour prepared from the soy bean, having approximately the following composition: Protein, 45.5; carbohydrate, 25.5, of which less than one-half readily yields sugar; fat, 8.5; ash, 6.0; fiber, 4.7, and water, 9.5. Cellu soy bean flour may be used for preparing bread and muffins in cases in which a diet relatively free from carbohydrate is desired, as in diabetes and amylaceous dyspepsia. The

Chicago Dietetic Supply House, Chicago.

Cellu Soy Crisp.—A prepared "breakfast food" made from cooked soy beans without removal of fat and having approximately the following composition: Protein, 45.6; carbohydrate, 16.1, of which less than one-half readily yields sugar; fat, 20.8; ash, 6.7; fiber, 6.8; and water, 4.0. It may be used in cases in which a diet relatively free from carbohydrate is desired, as in diabetes and amylaceous dyspepsia. The Chicago Dietetic Supply House, Chicago.

Mead's Powdered Boilable Lactic Acid Milk.—A modified product prepared by adding lactic acid U. S. P. to whole milk, drying and powdering. Each 100 Gm. contains approximately protein, 26 Gm.; lactose, 36.3 Gm.; butter fat, 27.2 Gm.; free lactic acid, 3 Gm.; ash, 6 Gm., and moisture, 1.5 Gm. Mead's powdered boilable lactic acid milk is proposed for overcoming the so-called buffer action of cow's milk in the infant's stomach. Mead Johnson & Co., Evansville, Ind.

Diphtheria Toxoid-Diphtheria Anatoxin.—The toxin of diphtheria modified by the method of Ramon. The work of G. Ramon of the Institute Pasteur has shown that the toxin of diphtheria may be modified by treatment with formaldehyde to reduce its toxicity and yet preserve its antigenic properties. Diphtheria toxoid is used for active immunization against diphtheria. It is administered subcutaneously.

Diphtheria Toxoid-Mulford.—Anatoxine-Ramon.—Prepared from broth cultures of diphtheria toxin having an L-plus dose of 0.25 cc. or less, diluted with physiologic solution of sodium chloride and free of serum proteins. It is marketed in packages of one immunizing treatment and in packages of ten immunizing treatments. H. K. Mulford Co., Philadelphia. (*Journal A. M. A.*, August 4, 1928, p. 321.)

Protein Extracts Diagnostic-P. D. & Co.—In addition to the products listed in New and Nonofficial Remedies, 1928, p. 42, the following have been accepted: Cotton Protein Extract Diagnostic-P. D. & Co.; Cotton-Seed (Cake) Protein Extract Diagnostic-P. D. & Co.; Goat Hair Protein Extract Diagnostic-P. D. & Co.; Human Hair Protein Extract Diagnostic-P. D. & Co.; Kapok Protein Extract Diagnostic-P. D. & Co.; Peptone Protein Extract Diagnostic-P. D. & Co.; Poplar-Pollen Protein Extract Diagnostic-P. D. & Co.; Sunflower Pollen Protein Extract Diagnostic-P. D. & Co.; Sweet Vernal Grass Pollen Protein Extract Diagnostic-P. D. & Co. Parke, Davis & Co., Detroit. (*Journal A. M. A.*, August 11, 1928, p. 397.)

PROPAGANDA FOR REFORM

Nature's Way Reducing Cream.—Health Laboratories, Ltd., Chicago, are able to get fifteen dollars for a few ounces of a harmless, but worthless, mixture of "oil, wax, epsom salt, baking soda and alum" sold under the claim that, when rubbed on the human body, it "reaches the excess fat deposits immediately underneath and slowly dissolves them." The claim is made that the product dissolves the fat deposits by reversing the natural processes of excess fat storage in the human body. The idea that a woman with "abnormal breasts, large hips or heavy thighs" can reduce the size of these portions of her anatomy by rubbing on a mixture of petrolatum, mineral oil, beeswax, epsom salt, baking soda and alum is so fantastic that the thing would be farcical were such ignorance not tragic. (*Jour. A.M.A.*, July 21, 1928, p. 190).

Iosaline Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that according to information supplied by the Iosaline Co., Inc., Iosaline is a mixture containing potassium iodide, equivalent to 5 per cent of iodine; menthol, 1 per cent; methyl salicylate, 12 per cent; alcohol, 70 per cent. Only indefinite statements of composition appear on the label and in the advertising. The Council reports that, although it is well known that potassium iodide is not absorbed to any extent when applied to the skin, the advertising claims that the iodine of Iosaline is readily absorbed. The Council held the preparation unacceptable for New and Nonofficial Remedies because the quantitative composition is not declared on the label and in the advertising; because its name is not descriptive of its composition, and because it is sold with unwarranted therapeutic claims. (*Jour. A.M.A.*, July 21, 1928, p. 173).

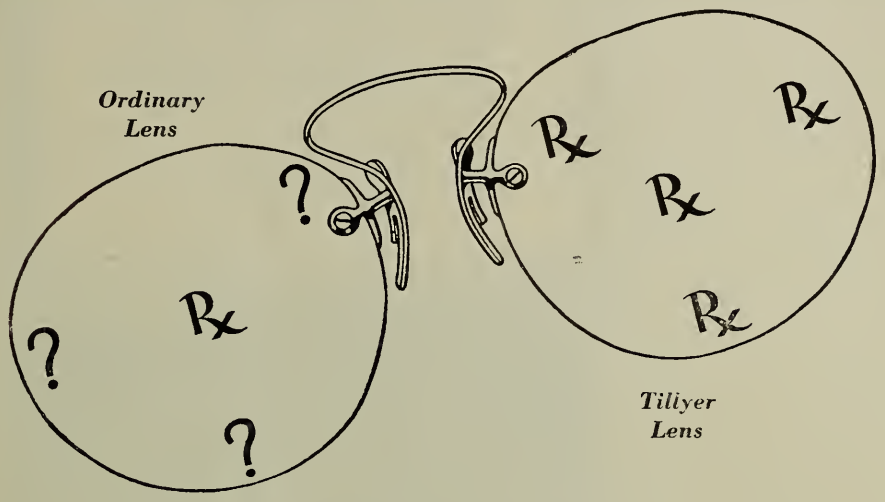
More Misbranded Nostrums.—The following products have been the subject of prosecution by the Food Drug and Insecticide Administration of the United States Department of Agriculture which enforces the Federal Food and Drugs Act: Syrup Dublanc (The National Drug Company) containing phosphates, lime, iron, iodides, benzoate of soda and sugar. Agmel (The Agmel Corporation) consisting essentially of a concentrated plant juice containing approximately 60 per cent of sugars (sucrose and invert sugar). Sauer Ju (C. M. Bogle Packing Company) found to be sauer kraut juice. Acid-O-Phil Tablets (H. K. Mulford Company) found devoid of *Bacillus acidophilus*. Crazy Mineral Water (The Crazy Well Water Company) labeled so as to give the impression that the water was a cure for rheumatism, constipation, functional stomach diseases, liver diseases, cystitis, diabetes, Bright's disease, etc. (*Jour. A.M.A.*, July 28, 1928, p. 265).

Cargel Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that "Cargel" is the proprietary name applied by the H. K. Mulford Company to an emulsion of lanolin in an aqueous solution of mild silver protein and casein. According to the information furnished the Council, the mixture is prepared by dissolving casein in an alkaline solution of sodium, potassium and calcium hydroxides, incorporating an amount of lanolin equal to the casein, and adding a solution of mild silver protein in such amount that the finished product contains from 1 to 1.25 per cent of metallic silver, equivalent to a five per cent mild silver protein solution. The preparation is a pharmaceutical mixture, which does not present any special originality or striking advance, and which, therefore, is not entitled to a coined name under the rules governing the Council in the recognition of proprietary names for mixtures. Furthermore, the Council held the name misleading since, according to the manufacturer, it was intended to indicate that the substance is a "gel", whereas in fact it is merely a creamy emulsion. The Council declared "Cargel" unacceptable for New and Nonofficial Remedies because the name is misleading and is not descriptive of the composition of the product to which it is applied. (*Journal A. M. A.*, August 4, 1928, p. 321).

The Injection Treatment of Varicose Veins.—The injection treatment for the obliteration of varicose veins is attracting increasing attention. The French school, under the leadership of Sicard, has been using sodium salicylate in solutions of from twenty to forty per cent. Linser used twenty per cent sodium chloride solution, and reported 6,000 injections. Noble, in Germany, has made injections in 3,000 patients with fifty per cent dextrose. Meisen uses equal parts of twenty-five per cent solution of sodium salicylate and ten per cent sodium chloride. In this country, McPheeters has reported favorable results with sodium salicylate. The most important consideration in connection with the injection method is the danger of pulmonary embolism. Thus far, reports of four cases of fatal pulmonary embolism seem to be available. Of these, two occurred after correct technic and therefore appear unavoidable. Against these two fatalities there are reports of 14,000 successful injections. The efficacy of the method will depend much on the proper selection of cases. Definite contraindications to the injection method include cardiac and renal disease accompanied by venous stasis and dilatation of veins, hypertonus, changes in and obliteration of the

(Continued on adv. p. xx)

to
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TRUTH ABOUT MEDICINES

(Contiuued from page 426)

deeper veins, pregnancy, and large intrapelvic tumors. (*Jour. A. M. A.,* August 4, 1928, p. 322.)

Eu-Med Not Acceptable for N. N. R.—The Council on Pharmacy and Chemistry reports that Eu-Med is a preparation manufactured by Dr. Tell & Company, Berlin, Germany, and distributed in the United States by The Oralee Company, Cleveland, Ohio. The preparation is marketed in the form of tablets which are claimed to contain 0.05 Gm. of caffeine and 0.15 Gm., each of acetphenetidin, antipyrine and amidopyrine. The advertising advocates the promiscuous use of the tablets for a large number of conditions. This indiscriminate use is encouraged by such statements in the advertising as: "Eu-Med is an absolutely harmless remedy which can be used without any fear by every physician and may be prescribed together with any other medicine." A circular intended for dentists states: "This remedy has proven successful in all cases. Nervous pains, for instance, trigeminusneuralgia, headache of every description, toothache, woundache, after the end of a local anesthesia, are eliminated with 'Eu-Med'." In the advertising it is stated that the name Eu-Med is short and therefore easy to remember and that it means "good medicine". Each tablet has the name "Eu-Med" stamped on it. This, with its suggestive name, invites its promiscuous use by the public. The Council found Eu-Med unacceptable for New and Nonofficial Remedies because it is a complex, irrational mixture marketed with unwarranted therapeutic claims under a nondescriptive therapeutically suggestive name and in a way to invite its indiscriminate and ill advised use by the laity. (*Jour. A. M. A.,* August 11, 1928, p. 397.)

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ORIGINAL ARTICLES

THE LABORATORY AS AN AID IN PULMONARY TUBERCULOSIS*

WILLIAM H. ORDWAY, M.D.

PHYSICIAN IN CHARGE, METROPOLITAN LIFE INSURANCE COMPANY SANATORIUM

MOUNT MCGREGOR, N. Y.

The trend of modern medical study is constantly toward a specific test or reaction that will permit the examining physician to unequivocally state that his patient is suffering from a particular disease. Commendable as this objective is, it undoubtedly narrows the clinician's power of observation and dulls his differential acumen. In early pulmonary tuberculosis, perhaps more than in any other disease, the conscientious practitioner becomes befogged in an atmosphere of uncertainty and gropes his way to the laboratory and x-ray room with hope uppermost that either or both of these departments can confirm a diagnosis he hesitates to make. When one considers the insidious onset of tuberculous infection, its inherent tendency to heal if given an opportunity, and its undemonstrative nature, symptomatically, it must be conceded that the chances of this disease to escape detection are manifold and devious. Unfortunately the position that the Wassermann test occupies in syphilis has no analogue in the diagnosis of tuberculosis, and, as Krause[1] has so aptly stated. "No laboratory procedure, taken by itself, can at present carry the whole load in the positive diagnosis of tuberculosis." The host of special tests for tuberculosis disease is but mute evidence of the lack of any reliable method. Each special procedure has had its day, leaving behind a few tried and seasoned examinations, and it is my purpose in this short period to outline our experience with some of these laboratory methods, omitting the x-ray for reasons of brevity.

The one outstanding examination of greatest value in the diagnosis of tuberculosis is the discovery of tubercle bacilli in the sputum. This procedure, relatively simple but frequently neglected and often carelessly done, is commonly the stumbling block either to a complete or correct diagnosis. At the company's sanatorium as high as eighty-two per cent of the patients admitted in one year had never had the benefit of this examination, and yet one-half of these cases had tubercle bacilli in the first specimen of sputum to be examined after admission.

The limited time allotted this paper does not permit a detailed account of the proper technic in collecting and examining a specimen of sputum. Krause's[2] article on "Laboratory Diagnosis of Pulmonary Tuberculosis" is an excellent exposition of the numerous pitfalls, and a resume of this portion of his article may not be altogether amiss. The patient must be acquainted with a description of what the sputum is, its source, when and how it is to be "raised", the proper "toilet" of expectoration, its collection in a suitable receptacle properly cleansed with soap and acid and the avoidance of contamination, and its delivery to the examiner in a fresh state. In children and infants the examination of throat swabbings and a search of the feces are indicated for the reason that tubercle bacilli that have been swallowed may be found in the stools. One is frequently surprised to find how many adults, especially women, who deny having expectoration unconsciously swallow their sputum, thus permitting bacilli to enter the intestinal tract.

Careful search of the specimen of sputum should be made for small flecks of opaque yellowish material—particles of pus from the tubercle which frequently harbor tubercle bacilli. Likewise the finding of the so-called rice bodies—bits of disintegrating caseous tissue—in the sputum may be expected to show bacilli in great abundance.

At the company's sanatorium we count the period of initial residence as of vital importance in the examination of the sputum, insisting that the preliminary sputum may afford our only chance of detecting the bacilli, since with rest the expectoration may cease altogether. Hence, concentration and guinea pig inoculation tests of all sputa in cases of suspected tuberculosis and definite pulmonary tuberculosis with negative sputum reports are a routine procedure. It is advisable to inoculate two guinea pigs subcutaneously with the

*Presented before the general meeting at the annual session of the Indiana State Medical Association, held at Gary, September, 1928.

specimen in question, since a single animal may die of an intercurrent infection. With two animals it is possible to sacrifice one at the end of sixty days, provided clinical observations and tuberculin test suggest it. The remaining guinea pig should be allowed to live one hundred twenty days or longer. In some instances positive results have been obtained in these pigs for the reason that an organism of low virulence or infection with a very few bacilli may require a longer period for development.

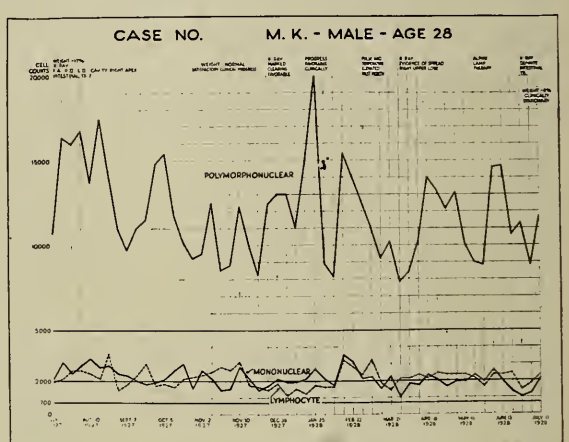
Repeated examinations of the sputum are essential. A negative result after numerous and repeated examinations necessarily makes one carefully weigh the possibilities of a non-tuberculous disease, such as bronchiectasis, abscess, bronchitis, or the more infrequent bacterial and fungus diseases that attack the lung. A more intimate acquaintance with the interpretation of x-ray films has brought out the fact that we are apparently encountering more cases of bronchiectasis than we did formerly. Whether this is due to better technic, increased incidence, or an awakening recognition, cannot be definitely determined. The usual textbook picture of this disease is woefully lacking in the early cases, and to my mind there is the same need for stimulation to discover patients with bronchiectasis as that which has been applied to tuberculosis. A far advanced case of bilateral bronchiectasis deserves fully as much sympathy as the advanced consumptive. Physical signs at either base are just as frequently absent as they are present. The injection of lipiodol affords the only means of clinching the diagnosis in early cases.

In the examination of the sputum it is particularly important in cases with an initial hemoptysis to demonstrate the bacilli in order that valuable time may not be wasted in arresting the disease. The demonstration of a single bacillus or two in any specimen for examination can hardly warrant a positive diagnosis and should await a more generous confirmation supported by positive culture or guinea pig inoculation.

It is to be hoped that Corper's[3] method of culturing the sputum will lead to a more frequent demonstration of bacilli in the expectoration, but our experience with this procedure is too limited to give an opinion of its reliability.

The frequent inability to find tubercle bacilli in pleural effusions makes a guinea pig inoculation of the fluid mandatory.

For the past two years Dr. Medlar[4] of our research laboratory has been studying the leukocyte count in about two hundred cases of advanced pulmonary tuberculosis. In the neighborhood of five thousand counts and differentials have been made; some cases have had weekly counts over a period of a year and a half. Based upon the pathogenesis of the tuberculosis process he feels that the mononuclear leukocyte forms the primary tubercle and participates largely in the repair of caseated lesions. The neutrophile is the cell chiefly responsible for tuberculous abscess formation. He discards entirely the theory that the polymorphonuclear leukocyte is an indicator of mixed infection. The lymphocytes participate in the healing stages of tubercle and in the reparative process following caseation. The eosinophile and basophile do not seem to enter particularly into any phase of the tuberculous picture and hence may not be assigned any particular role. Both may be increased in the circulating blood. In order to obtain the normal standard he studied seventeen individuals in New York city at weekly intervals for a period of three months. All members in this experiment were carefully selected physically and by x-ray to establish their fitness for this investigation. His deductions place the mode of the total leukocyte counts between six thousand and nine thousand, and total neutrophiles between three thousand and five thousand seven hundred sixty per cmm.; lymphocytes one thousand six hundred to three thousand five hundred and seventy; monocytes three hundred sixty to eight hundred ten; eosinophiles sixty to two hundred seventy, and basophiles thirty to ninety. The upper limit of total neutrophiles has been arbitrarily placed at five thousand per cmm., lymphocytes at two thousand per cmm., and monocytes at seven hundred per cmm. By plotting the counts at weekly intervals taken between 9:30 and 10:00 a. m. we have been able to learn something of the progress of the patient not always discernible from the clinical aspects of the case. From the leukocyte count the



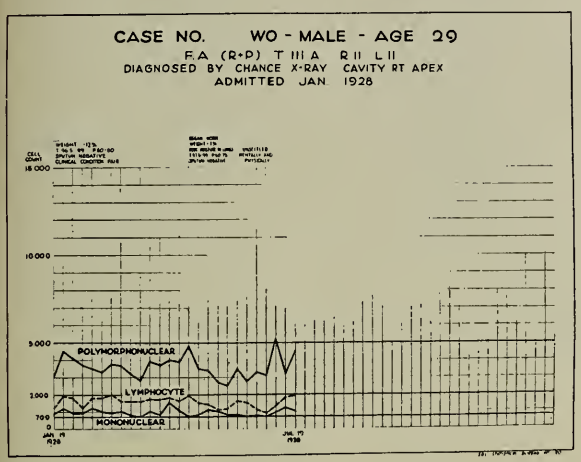
No. 1

tuberculous cases arrange themselves into three distinct groups:

The septic type, presenting a normal or increased leukocyte count with a definite increase in the total neutrophiles and monocytes and a decrease in total lymphocytes. Such a reaction is indicative of abscess formation.

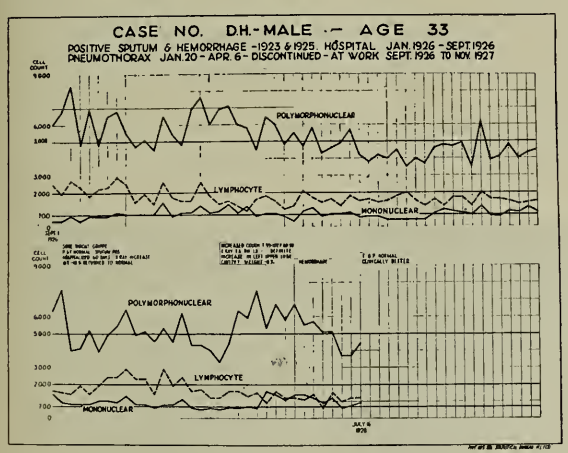
The second, or non-septic type, shows total counts varying from five thousand to ten thousand.

The differential percentages are as follows: neutrophiles forty-eight to fifty-five per cent, lymphocytes thirty-three to forty-five per cent, mononuclear leukocytes eight to fifteen per cent, eosinophiles one to ten per cent, basophiles one-half to two per cent. A disposition on the part of the patient to maintain this formula implies healing, with a good prognosis.



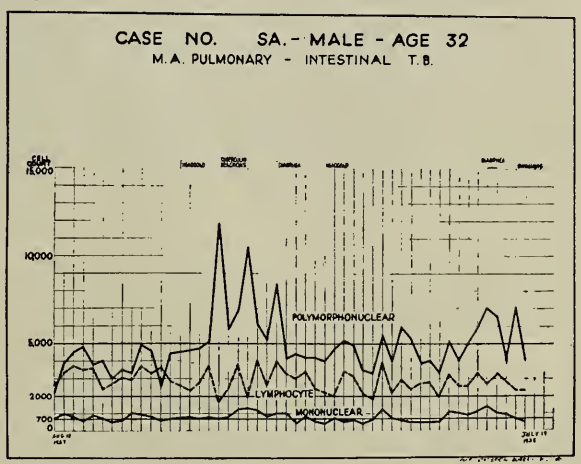
No. 2

The third, or intermediate group, demonstrates an inconstant fluctuation of the leukocytic picture from a non-septic to a septic type. Such cases do not do well unless they can establish and maintain the non-septic classification.



No. 3

In the first or septic type the prognosis is unfavorable and unless the case shows a tendency to slip into the intermediate or non-septic group they succumb to the disease. Twenty-three such patients have died and sixteen were autopsied. All of these have shown the septic leukocytic formulae in the differential counts. Some have had a low total count, while others have exhibited a constant leukocytosis. One of our research laboratory workers on full time duty except for a two-hour rest period in the afternoon, suffering from moderately advanced pulmonary tuberculosis complicated by a tuberculous enteritis, has been continuously observed for over one year. While in the act of making tuberculin he accidentally inhaled the fumes from an open flask. That evening he was ill with a temperature of one hundred four, chills and general malaise. His blood count the next day showed a definite reaction to the septic type. He promptly recovered from this reaction and three weeks later repeated the same performance while making another quantity of tuberculin. His clinical symptoms were not quite as marked in the second reaction as in the first. His recovery from the second dose was delayed somewhat, both clinically and by blood count.



No. 4

From the foregoing it is not to be inferred that the leukocytic reaction is in any sense a diagnostic aid, nor is there any constant formula. It may, however, yield suggestive information. Weekly estimations, we feel, permit one to obtain indications as to the pathological state of the tuberculous lesion. If such is the case the leukocyte count can be of definite service in augmenting clinical judgment as to the precise time to prescribe exercise and its subsequent control.

An aid of real merit in the diagnosis of tuberculosis is the testing with old tuberculin, preferably the intracutaneous reaction. In certain instances the Von Pirquet test, especially in children and in the timid, may be the method of choice. This test, as suggested by Krause, should be done with potent tuberculin and carefully observed by the physician himself. A positive reaction indicates a tuberculous infection within the organism—nothing more. With a few rare exceptions a negative reaction to the intracutaneous tuberculin stamps the individual as non-tuberculous.

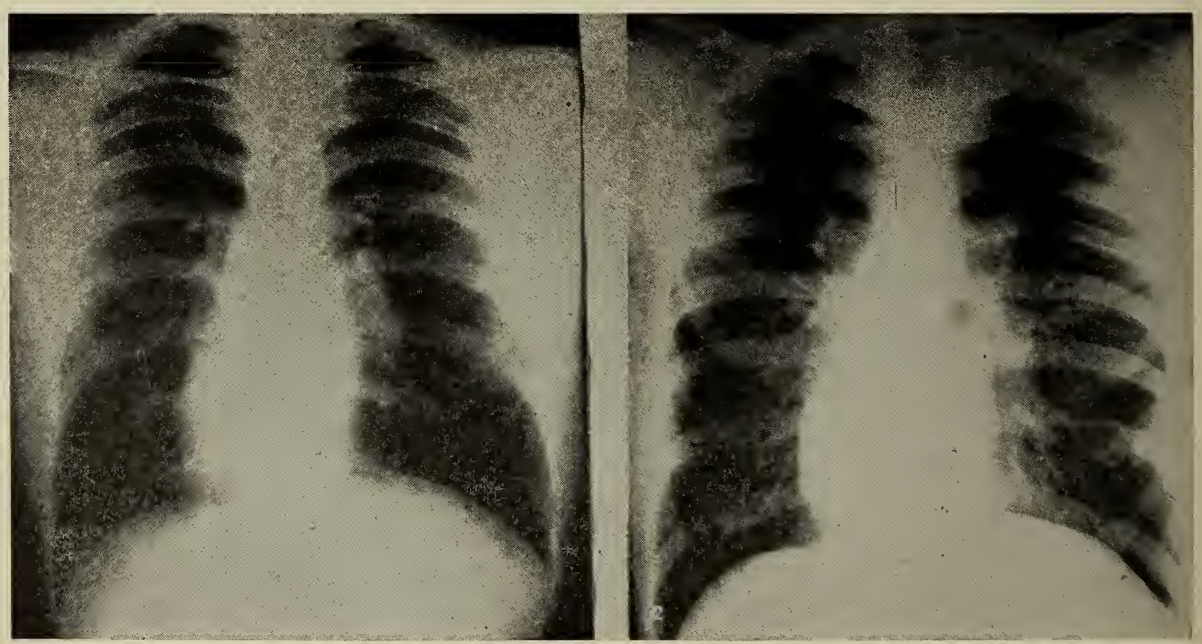
With the rapid decline in the mortality for tuberculosis throughout this continent, particularly in the United States, and with the vast increase in sanatorium facilities for tuberculous patients, there has been a diminished opportunity for infection of the general population, consequently

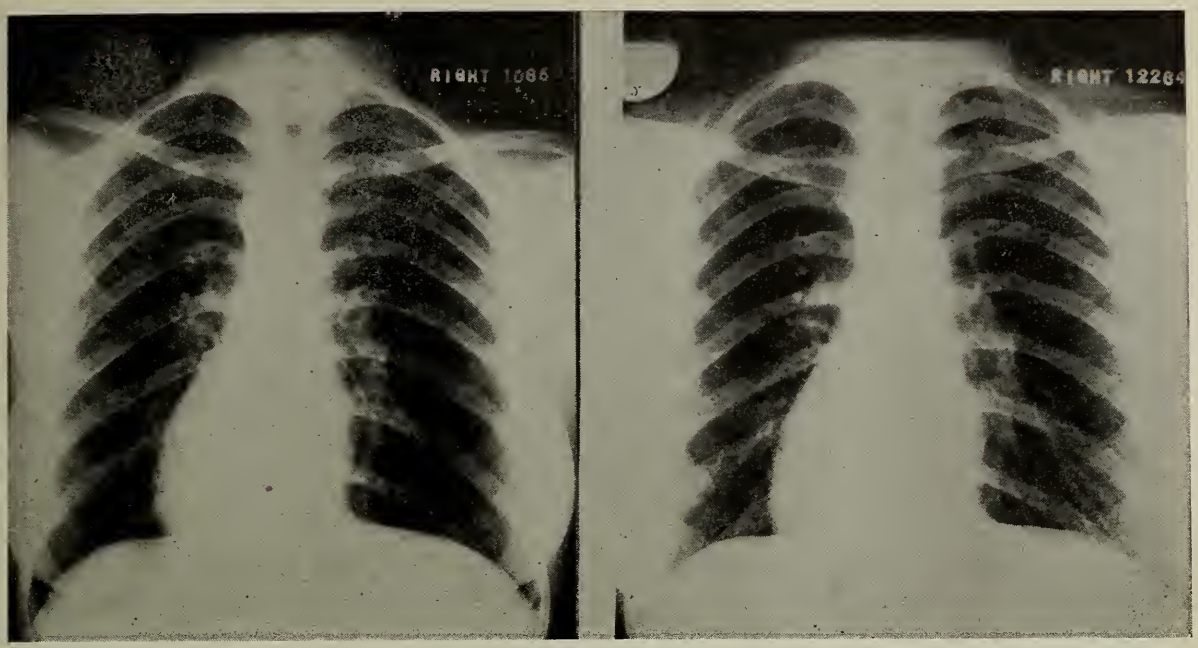
the universality of tuberculous infection is becoming less and less a professional by-word. The number of adults who do not react to tuberculin is increasing and one is frequently brought up short to the realization that he is dealing with a non-tuberculous pulmonary lesion.

At Mt. McGregor where we receive non-tuberculous as well as tuberculous patients, we are constantly confronted with the so-called tuberculous suspect and many borderline cases which call for a definite decision as to their pulmonary infection. In the past we have been in the habit of giving subcutaneous diagnostic tuberculin, but of late we are gradually inclining to the opinion that a negative subcutaneous tuberculin (O. T.) beginning with one-tenth of a milligram and gradually increasing until ten milligrams have been twice repeated, is not as accurate a diagnostic aid as is supposed. On the other hand, there is some question in our minds, as has been previously suggested, that it may do actual harm. In a report to be published shortly we shall attempt to show that a certain number of cases have developed a definite pulmonary tuberculosis following a negative subcutaneous injection of tuberculin. A few cases from this group have been selected:

Case I—male, nineteen, clerk; admitted to sanatorium June 24, 1925, convalescent from a fracture of the right tibia. Father died of tuberculosis of throat. Physical examination uninteresting. X-ray plates of chest negative. Sputum 0. Discharged September 15, 1925, improved. Readmitted January 1, 1926, with the history that in October, 1925, he contracted a cold and had pleuritic pain in right chest; was ill five weeks. At the end of the sixth week he developed an effusion and with thoracantesis a small amount of fluid was obtained; some cough and expectoration present; twelve per cent below normal net weight on admission. Physical examination negative except for old fracture of tibia and a few inconstant rales at right hilum posteriorly. X-ray examination of of chest on this admission showed obliteration of right costo-diaphragmatic angle and pleural thickening in mid lobe region, and a questionable amount of fine mottling at right apex. On account of the increase in findings in these plates as compared with the previous ones, diagnostic tuberculin (subcutaneous) was given, but he failed to react. He was discharged May 1, 1926, improved, with a diagnosis of convalescence from serofibrinous pleurisy. As a result of our follow-up routine on discharged patients this man was x-rayed at our Home Office in New York City in April, 1928, at which time he showed a marked increase of the mottling from the hilum and involving the upper lobe. Since then he has left the employ of the company and cannot now be located.

Case II—female, nineteen, clerk; admitted to sanatorium March 24, 1927, diagnosed in New York City as a case of chronic bronchitis. Mumps the only disease of childhood. Family history negative for tuberculosis. Present illness began with a cold in September, 1926, preceded by a tonsillitis; tonsillectomy done in October, 1926; good recovery except frequent colds. In January, 1926, was ill three weeks with grippe; ill in March, 1927, with sharp pain in right lower chest, dry cough, lost five pounds in weight. Physical examination: Four per cent above normal net weight; thyroid definitely enlarged; deviation of nasal septum and hypertrophy of inferior turbinates. Pulmonary examination negative except for a few clicks at left hilum anteriorly. X-rays were read as suspected tuberculosis. Laboratory examinations negative. Failed to react to ten mg.





No. 6

of subcutaneous tuberculin April 15, 1927. Discharged June 11, 1927, with diagnosis; deviation of nasal septum, hypertrophy of inferior turbinates (cured by operation). In December, 1927, she had another attack of bronchitis and was in bed until January 9, 1928. X-ray taken January 13, 1928, at Home Office showed a definite increase over the previous examination and she was readmitted to the sanatorium January 24, 1928, as a case of incipient pulmonary tuberculosis. X-ray studies at this time showed marked increase in the left apex described as a large patch of parenchymatous infiltration extending to clavicle and third v. s. No physical findings in lungs. Patient discharged September 6, 1928, quiescent.

Case III—female. twenty, clerk, entered sanatorium December 14, 1925, with a diagnosis of pulmonary tuberculosis. Measles, chicken pox in childhood; malaria at seven and twelve; tonsillitis at nine and seventeen; double pneumonia at eleven; asthma from early childhood to fourteen; tonsillectomy at seventeen; tendency to colds and sore throats. Present illness began in June, 1925, with fatigue and anorexia; recovered in part but in August it recurred, accompanied by cough, expectoration and indefinite chest pains lasting for two months. In November, 1925, she had grippe. Physical examination: Three per cent below normal net weight; pale; lungs show few rales at right apex. Head sinuses by x-ray showed questionable ethmoiditis. Films of chest showed a suspected tuberculosis. Laboratory examinations negative. No expectoration. On February 8, 1926, she was given a full course of diagnostic subcutaneous tuberculin and failed to react. Following discharge in May, 1926, she returned to work and was well until 1928, when she experienced a return of her symptoms. X-ray films of chest April 28, 1928, showed a moderately advanced tuberculous, R. 11, L. 11. No expectoration obtainable. No evidence of moisture in chest.

Case IV—female, twenty-one, clerk; admitted to sanatorium June 23, 1927, as a tuberculous suspect. Measles, chicken pox, whooping cough in childhood; age six to fourteen frequent sore throats; at thirteen had influenza. Family history negative except one brother died at seventeen of heart disease. Present illness began in April, 1927, with an attack of pneumonia; ill six weeks; lost twenty-five pounds in weight; cough and bloody expectoration during illness, none since. Physical examination: Pale, fifteen per cent above normal net weight; temperature generally subnormal; pulse ninety to one hundred. Lungs showed small effusion at right base anteriorly and posteriorly. X-ray of chest was read as moderately advanced pulmonary tuberculosis and pleurisy with effusion, right. Thyroid slightly enlarged symmetrically. Two abscessed teeth; tonsils cryptic. Laboratory: no expectoration; basal metabolism plus nine per cent; complement fixation for tuberculosis two plus. Fluid aspirated from right chest in July, 1927, was bloody but proved negative to bacteriological examination. September 21st, a guinea pig inoculated with the sputum was negative. September 30, 1927, was given diagnostic tuberculin and failed to react. X-ray examination of the lungs in September showed no change. In November she had a small pulmonary hemorrhage; sputum was negative, but a guinea pig inoculation gave positive findings. Repeated x-ray of chest on November 1st showed an increase in the root region of the left lung and an invasion of the midzone, particularly in the first



No. 7

and second i. s.; there was also a lessened transmission of ray at the base suggesting fluid. In April, 1928, there was marked increase in both lungs and an increment in the fluid at the left base.

From the foregoing cases it is evident the dictum that tuberculosis rarely develops in patients failing to react to diagnostic subcutaneous tuberculin is certainly open to question. It is to be admitted that the first three cases do not prove that the patients are now tuberculous. All that one can venture is that the films of the chest are strongly suggestive of tuberculosis. The last case seems definitely conclusive.

Much has been written in the literature concerning the sedimentation rate of the erythrocytes and its value in the diagnosis and prognosis of pulmonary tuberculosis. Sasano and I[5] have studied the test in one thousand individuals, including one hundred seventy-five normal employees; the remainder were tuberculous and non-tuberculous male and female patients. This investigation was begun in 1923 and has been continued to date, repeated observation being made in all cases every



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two or three months as long as the patient remained in the sanatorium.

In the tuberculous cases a high sedimentation is commonly found in the acutely ill, advanced case, and sometimes in the incipient cases. A decrease in the sedimentation rate is generally co-existent with improvement in the clinical condition, and the reverse in bed patients implies a poor prognosis. The majority of suspected, incipient and advanced quiescent cases give a normal or questionable rate of sedimentation. A normal rate in tuberculous cases is generally of good prognostic import, but does not exclude the presence of active disease.

The sedimentation test is nonspecific and is apparently increased in any disease causing damage to the body tissues. We think that the test considered as the sole guide in tuberculous processes would give misleading information. One fact stands out, however—the greater the sedimentation rate the greater the mortality rate in both the tuberculous and non-tuberculous cases. The high percentage of increased rates in apparently normal individuals makes the test untrustworthy.

SUSPENSION STABILITY OF ERYTHROCYTES

	Normal Rate	Questionable Rate	Pathological Rate
Normal	114—65%	43—25%	18—10%
Far advanced	13—13%	6— 6%	83—81%
Moderately advanced	49—35%	22—16%	67—49%
Incipient	86—64%	20—15%	29—21%
Suspected T. B.	17—65%	4—16%	5—19%
Non-tuberculous	217—51%	86—20%	121—29%
Total	496—49%	181—18%	323—33%

The use of the complement fixation test in tuberculosis is still on probation and must be used with more or less reserve in the diagnosis and prognosis of this disease. With improved technic Sasano[6] has been able to obtain results as shown in the table following:

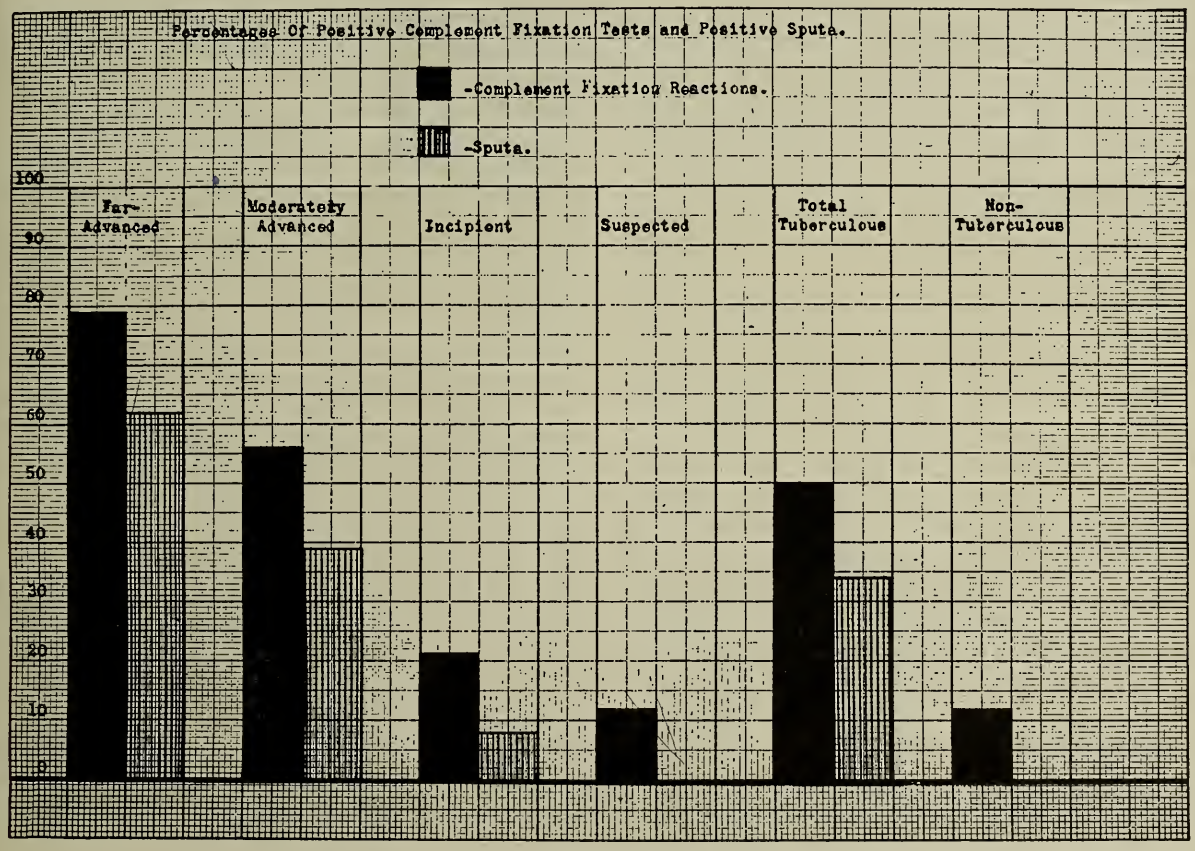
However, the test is non-specific, as demonstrated in a study of four hundred forty non-tuberculous patients in which thirteen per cent were strongly positive, twelve per cent doubtful and seventy-five per cent negative.

From the foregoing it is obvious that the usefulness of the laboratory in pulmonary tuberculosis is directly proportional to the diligence one applies in technic, and to the perseverance one utilizes to exclude conditions which so closely simulate this disease. Of outstanding importance in diagnosis is the examination of the sputum and the skin tuberculin tests. The use of continued weekly total and differential leukocyte counts can be of service in the management of the case.

Discussion

Eric A. Crull, M.D., (Fort Wayne): I think we should all be very thankful to Dr. Ordway for the very splendid and thorough message he has given us on the laboratory work in tuberculosis. It does not surprise me that it should be thorough, because Dr. Ordway is connected with an organization that does more public health work than any other in the world, and he also happens to be superintendent of probably the finest tuberculosis sanatorium in this country.

I am embarrassed because of the fact that I



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am not a laboratory man. I hardly know the difference between a microscope and a centrifuge; but being one of the men who is essentially interested in the reduction of mortality and the incidence of morbidity from tuberculosis in Indiana, I am doubly pleased to get Dr. Ordway's findings, and to hear him state the conclusion that most of us who have been in this work for years have reached, namely, that laboratory aids, so far as the tuberculous proposition is concerned, taken by themselves, are not always reliable. In other words, the sedimentation test, and other tests, are interesting and in a measure have been helpful, but when it comes to the proposition of making a diagnosis they frequently leave us absolutely up in the air; we cannot make a definite diagnosis.

Since, as far as laboratory work is concerned, we have just one absolutely positive and specific test, and that is the finding of the tubercle bacilli in the sputum, I want to urge that a single examination of the sputum is not sufficient. We have allowed the laity to believe that one or two examinations of the sputum can tell us something about the patient's condition. I am satisfied that the State Laboratory gets specimens of sputum every day that are not repeated. Someone sends sputum to the laboratory, the report comes back negative, and many times the physician says, "You are all right. You do not have tuberculosis. Your sputum is negative." The fact of the matter is that two or three such examinations mean absolutely nothing, if negative. I insist that nothing less than eight or ten sputa, run daily, will give us any reliable information in regard to the tubercle bacilli. Records of sanatoria will show that they have patient after patient whose sputum goes to the laboratory daily, and for the first week or ten days it will be negative, and then suddenly it is positive. Again we meet with the old fibrotic case with negative sputum for a whole year, and then the patient develops a coryza and suddenly the laboratory report comes back with Gaffky[8]. Of course the presence of the tubercle bacilli is virtually conclusive. Some people, Laurason Brown, for instance, say that the positive sputum is not indicative of active tuberculosis—that it means a diagnosis but is not diagnostic of activity.

In Indiana the statisticians tell us positively and definitely that if in this state the mortality is reduced from year to year as it has in the last ten years, that in 1968 there will be no tuberculosis in Indiana. That sounds like a dream, but I believe it can be accomplished. When years ago the slogan came, "No More Typhoid", we thought it was a dream; but now we know that a case of typhoid is a disgrace to a community and is absolutely preventable.

I wish Dr. Ordway in closing would make a little plainer his stand on the von Pirquet test. That is another thing that is used so freely and quoted so readily by the average physician. The idea seems to prevail that it is diagnostic. Dr. Ordway said a little about it, but I am curious to know what his experience has been with its use in children, and what significance he attaches to it.

I agree with him that the subcutaneous test with tuberculin is sometimes very valuable, but you can test a patient years after you have given tuberculin and find him clinically well, and yet if you then give him one-tenth milligram you will have a violent reaction.

On the subject of the x-ray, I feel it is a wonderful help, but again I would like Dr. Ordway to tell us whether he believes that he or any other man can ever make a diagnosis of active tuberculosis from an x-ray plate. My opinion is that for every one hundred men in this country today who spend their time in this work and believe that they can judge of the activity of the disease from the x-ray plate, there are one thousand who say that it cannot be done reliably.

So, going back to diagnosis, I believe the question of early diagnosis is a question of watching your patient, especially for the man far from a laboratory, being on the lookout for moist rales, hemorrhage from any place below the larynx, pleurisy with effusion, and a difference in temperature which is typical. We know that hyperthyroidism will give us a temperature, but I know of no other condition which, after we exclude the acute disorders, will give us the typical temperature found in tuberculosis.

I would also ask Dr. Ordway to comment on the hemoglobin, whether he finds the lower percentage is indicative of anything tuberculous. Some practitioners pay so much attention to this.

HENRY FREDERICK HELMHOLZ, M.D., (Rochester, Minnesota). I would like to ask Dr. Ordway what is his routine procedure in regard to the intracutaneous test for tuberculosis, what is his dosage, and whether if it is negative he is willing to say there is no tuberculosis present in the individual?

W. H. ORDWAY, M.D., (closing): With regard to the von Pirquet test that Dr. Crull asked about, it is merely an evidence of infection, nothing more, and the principle is the same as in the intracutaneous test. Our sanatorium experience is limited to adults; it is only in outside practice that we encounter children.

The diagnosis of tuberculosis from the x-ray standpoint is treading on dangerous ground, especially if one attempts to say that a case is active or inactive. Recently I was talking to Mrs. Sampson, of Saranac Lake, who feels that they are gradually coming to the point where they can tell whether a case is active or inactive from the x-ray standpoint, but I think such surmises belong to the field of the ultra-x-ray tuberculosis specialist.

As to the haemoglobin, I do not think we can

attach any real significance to a lowered haemoglobin. It is an indication of advanced toxemia, but in no sense can it be considered diagnostic.

In reply to Dr. Helmhholz' question about the dosage in the intra-cutaneous test, we start with 1/100 of a milligram, increasing successive doses by multiples of ten up to ten milligrams, injecting at three-day intervals until we get an indurated area of at least twenty by twenty millimeters.

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EXOPHTHALMIC AND ADENOMATOUS GOITRE*

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For the first time in the history of goitre study it seems probable that we can recognize a more constant pathology in goitre and understand more fully the wide variety of microscopic pictures presented. The work of Rienhoff[1] demonstrates the cyclic nature of the changes in goitre and the variations occurring in them throughout the progress of a case of hyperthyroidism. Previous beliefs and explanations of the microscopic picture have been ingenious and plausible, but the fact is that laboratory classification up to the present time has not regularly fit the clinical diagnosis. The twenty odd classifications of goitre are proof of this statement. Also many specimens, if several blocks were cut, became so confusing, that a pathological diagnosis was made with the greatest difficulty. It was a common occurrence in laboratories where serious effort was made to correctly classify specimens to find that various members reached different conclusions after study of the same section. Surgeons repeatedly have had the experience of sending a nodular gland to the laboratory with the complaisant belief that the specimen was a perfect example of so-called toxic adenoma only to receive a report that it was exophthalmic goitre. The exact reverse of such an occurrence happened just as frequently. And to make matters still more disconcerting the surgeon found when he studied the section that the clinical conception did not fit the microscopic appearance and he became still more perplexed as far as cataloguing a given case was concerned. Very often sections taken from different areas would permit of any diagnosis one wished to name. This is no exaggerated statement of the goitre problem from a histological standpoint.

The administration of iodine to patients with goitre, as a pre-operative measure, to cause a remission in the course of the disease has added to the confusion. In a general way the effect of iodine has been known. All observers have agreed that following its use there is a change in the colloid which becomes more abundant. It also combines with stain more readily and becomes homogeneous and refractile. The thyroid epithelium becomes less active and changes from columnar to the cuboidal or flattened types. Other changes involving stroma, lymphoid foci, blood vessels and acinar arrangement have not been agreed upon. Cattell[2], Rienhoff[1], Hertzler[3], Helwig[4] and Mosser[5] have recently published experimental or clinical observations and do not agree entirely on these points. These observations by different investigators have not been made under identical conditions. The amount of iodine given and the duration of administration have been variable.

Rienhoff studied goitre specimens from patients with hyperthyroidism before and after iodine administration. In addition to the hypertrophy and hyperplasia recognized as the probable essential features of hyperthyroidism he describes three types of regressive changes commonly occurring in the thyroid lobule and other changes occurring around it. The most extreme degrees of regression were termed involutional bodies and were represented by (1) large epithelial lined cysts containing colloid, (2) areas having the appearance of so-called "colloid adenomas" and (3) marked hyperinvolution, a state of disintegration.

Nodular goitre has usually been called adenomatous goitre, toxic adenoma, diffuse adenomatosis, etc., with the inference that the nodules were of the nature of true benign tumors. Rienhoff and Lewis[6] found that the thyroid glands of fifty patients who had had spontaneous remissions and exacerbations in the course of the disease were nodular and that these nodules were exactly similar to the involutional bodies described by Rienhoff as regressive changes occurring after iodine administration.

This conception is different from previous notions of goitre pathology even though it recognizes the essential nature of hypertrophy and hyperplasia. More emphasis is placed upon the regressive changes and it is pointed out that involution either spontaneous or artificial may produce follicular changes which are manifestly the eventual nodules of nodular goitre. The cyclic nature of the process from activity to regression and back again may be localized or diffuse and the gland grossly will be either nodular or not, depending apparently upon the degree of involution which occurs. They think it is obvious that the term "adenoma of the thyroid" is not correct when applied to these nodules which form the great majority of thyroid tumors. Nodules resembling true benign neoplasms were found by them in only eight per cent of one hundred and nine consecutive cases of nodular goitre.

*Presented before the general meeting of the Indiana State Medical Association, annual session, held at Gary, September, 1928.

Areas in which the average amount of involution did not occur were also present. This phase was termed hypoinvolution and the areas were considered to be due either to an undue resistance to the involution process or to the active process starting all over again. The contention that exophthalmic goitre and so-called adenomatous goitre are essentially the same is also made by them on the basis of the histological evidence presented.

I believe that a consideration of accumulated clinical experience substantiates the belief also. It has been felt for a long time that nodular goitres, the so-called adenomatous variety, responded to surgical removal with a much higher number of satisfactory results than did exophthalmic goitre. This belief was so general and had been held for such a long time that it seems it should be true. If these involutional bodies are one of the evidences of remission and make up the majority of nodules in goitres then we must believe that most of the "toxic adenomas" are cases of hyperthyroidism which have undergone spontaneous remission. On the whole this is a milder type of hyperthyroidism and of longer duration than Grave's disease. Hyperthyroidism, which has not undergone spontaneous remission, and has not developed involutional bodies has been classed as exophthalmic goitre. These two types have not been clinically and histologically distinct. So-called mixed types have occurred frequently and have been responsible for much of the dissatisfaction concerning the previous conception of the two. Under the usual present-day management many of the goitres which were previously termed exophthalmic are changed into nodular goitre by administration of iodine and the artificial remission which results. Not one of our specimens of the last two years is of the solid type with little or no colloid. Before this time the solid type was very common, and was diagnosed exophthalmic goitre whether nodules were present or not.

There are a few goitres which do not undergo the usual remission after Lugol's solution is administered. These patients while they account for only a small percentage of the total number of cases of hyperthyroidism are by far the most interesting ones. We may assume that these patients, though they behave differently, are essentially the same as the others but for some unknown reason are unduly resistant to the usual remission. It may be that they are fundamentally different in cause and nature and will not undergo remission under any conditions. The first supposition seems to be more probable, but whichever proves to be true this group of necessity must occupy our attention because of the problem it presents in the pre-operative preparation. Depending upon the behavior toward iodine, goitre patients with hyperthyroidism naturally fall into two groups, those which undergo remission readily and those which resist remission to a considerable degree or perhaps completely. Satisfactory handling will depend upon our ability to induce a remission of the disease and involution in the gland which tend to run parallel.

At the Indiana University hospitals we have two goitre specimens of this remission resisting type from patients admitted during the past year. These goitres are fundamentally not the same as nodular goitres or if they be the same, some factor influencing involution unfavorably was present. The microscopic picture is not the solid type of typical exophthalmic goitre. The average degree of involution is seen only in patches. Hyperinvolution is nowhere noticeable, hence involution bodies or nodules are not present. The patients were both in the hospital for months and from a clinical standpoint remissions were absent or of such mild degree that we were never certain about them. Histologically there is evidence of average involution in some areas which have well stained, homogeneous and refractile colloid. The epithelium is cuboidal or flattened and papillations are absent but scattered throughout each gland are many areas where the epithelium tends to be columnar, papillations are plentiful and the colloid is thinner and less refractile. These areas correspond to the hypoinvolution areas of Rienhoff and are an outstanding feature.

The use of iodine in goitre prevention as advocated by Marine is a well established measure and the report by Kimball recently of its extensive application is most convincing. However, the use of iodine as a therapeutic measure in goitre patients is not a uniformly beneficial measure although most of them experience some alleviation of the toxic symptoms. A goitre patient's reaction to the administration of iodine can not be predicted with certainty. Some merely fail to improve following its use while a few seem to be utterly intolerant to it. For years we have been advised to be careful in prescribing iodine to middle aged persons with goitre, especially those with nodular goitres. In asthma, cardio-vascular renal disease, cataracts, and many other conditions iodine is quite commonly used and is no doubt sometimes a factor in stimulating a quiescent goitre to activity. Such behavior is yet to be explained.

CONCLUSIONS

1. Evidence is accumulating that the majority of goitre patients behave similarly after iodine administration and undergo some degree of remission.

2. Hyperthyroidism which has undergone spontaneous remission with the formation of involutional bodies constitutes the majority of those cases we have been calling "toxic adenomas."

3. The general use of iodine in the pre-operative preparation of patients, converts by artificial remission many cases of hyperthyroidism of the type previously called exophthalmic to the nodular type.

4. A relatively small number of these patients for some reason resist the remission phase and constitute the chief problem in the surgical management of hyperthyroidism.

Discussion

Miles F. Porter, Sr., M.D. (Fort Wayne): I do not know that I can add very much to this paper. Perhaps the best thing I can do is to emphasize a few points by epitomizing, if you please, what has been said.

First, all goitres, whether they be classified as toxic, adenomatous, so-called innocent or inactive, or exophthalmic, are goitres just the same; they are part and parcel of the same process. But there is no such thing, in my judgment, as an "innocent" goitre. The innocent goitre is like the so-called "innocent" gall-bladder, like the old farmer's giraffe—"The' ain't no such animal." What is innocent goitre today will in the course of ten years become a typical nodular goitre, or a toxic adenoma. I cannot understand, and neither does the Doctor, why some of these individuals have a remission after the administration of iodine, and others do not. I think we can be positive today that what we have been talking about as toxic adenomas were not adenomas at all; only about two per cent of them should really be classed as neoplasms.

I would like to make one practical point, and that is this, regarding so-called innocent goitre. There is just as much reason for removing every goitre as there is for removing a suspicious mole, or wart, or lump in the breast, not because it will become malignant, but because it will give trouble by-and-by, and they should all, in my judgment, be removed for that reason.

I would like to emphasize what the Doctor said about the preliminary treatment of these foci of infection in cases that come with symptoms of thyrotoxicosis. I think we have been putting the cart before the horse. The thing to do is to remove the goitre first and then the other foci. It is the goitre that will kill the patient, not the local foci. The local foci do not produce the goitre and their removal does not cure it. My judgment is that we have been waiting entirely too long for these foci to be removed, but we have turned the rig around the other way and have the horse in front now, and we remove the goitre first and the other foci later. If you have the patient in bed and doing well, go ahead and remove the foci of infection, but if the patient is not getting better you had better leave the tonsils and teeth and take away the goitre.

I enjoyed the Doctor's paper very much, and anybody interested in the subject further will find it covered very well by three papers published in a recent number of the Archives of Surgery (January, 1928), two (Rienhoff and Lewis, and H. M. Thomas, Jr.) from Johns Hopkins, and one (A. E. Hertzler) from the Halstead clinic.

G. C. Eckhart, M.D., (Marion): I believe Crile classifies goitres as toxic and non-toxic. You have just heard the senior member of the surgical profession in Indiana, Dr. Porter, who many years ago made the statement that all benign, quiescent goitres should be removed. I have followed this plan over a period of years and found his statement to be true. How many of us have known people for years, seen them on the street and elsewhere, with a lump in the neck. Sooner or later they come to someone, and you learn the goitre has become active and they will have to submit to surgical treatment.

I also agree with Dr. Porter's statement that we have been getting the cart before the horse, and I think he takes the right stand in recommending the removal of the goitre first. I think this also is emphasized in the work done by Josline on diabetes—that the gangrene should be removed and the diabetes treated afterwards.

Dr. Little's paper is very timely and shows that the goitre problem at the present time is changed, since the introduction of iodine. It is quite different from five or six years ago.

Lastly, I wish to concur in the Doctor's last conclusion—that a certain small percentage of cases do not yield to iodine treatment. Just why, we do not know. Recently a young lady came to my office who belonged to this group. The reason I emphasize that is that within the last few months an internist made the statement that in diagnosing goitre if they did not yield to iodine treatment they could hardly be classified as goitre. I think that is open to argument, because if they do not yield to iodine they do yield to surgical treatment.

Goethe Link, M.D., (Indianapolis): This paper of Dr. Little's is a very fine one and shows that he has done a great deal of hard work in a particular department of this subject in which much work is needed, and about which we know very little. It is an unfortunate fact that if we send a section of a thyroid gland to a pathologist, we do not learn much from what the pathologist has to tells us, simply because he does not know very much about the pathology of the thyroid gland. It seems that the clinical knowledge has gone ahead of the knowledge obtained by the microscope and laboratory man. However, it is a fact that we can take a thyroid in the gross specimen, hold it in our hands, feel it, look at it, and tell something about the clinical history of the patient from whom this thyroid was removed. We do have classifications of the disease, of the stages of the disease of the thyroid, which are of help to us in managing these cases, and these classifications were produced by a clinical worker and by a physician rather than by a microscopist. I think we are entitled to hold to what helps us in taking these patients through in good shape, what seems to help us in managing these cases. Whether or

not it can be proven by the microscope is another matter.

Whether iodine acts upon the gland tissue, or by neutralizing its products is still undecided. We know its action on the gland from the clinical standpoint. In my own experiene it seems to me that the patient who has a tendency to exophthalmic symptoms—I do not need to describe them—is most benefitted by iodine. Some will be helped by iodine, and some will be made worse, but I think they show more improvement from iodine in the exophthalmic cases. If the patient has no tendency to exophthalmos, iodine may make him worse; but with a little tendency to exophthalmos iodine makes him better.

The use of iodine bears the same relation to thyroid disease that the use of morphine does to appendicitis. Iodine is an agent in the hands of the surgeon to prepare the patient for operation. Iodine will not cure the patient, and it should not be administered until after the patient has entered the hospital to be prepared for operation.

In regard to surgery, after all, it is surgery that cures these forms of thyroid disease, and as Dr. Porter says, we should take from our vocabulary the term "simple" goitre. There is no such thing. Thyroid disease is thyroid disease, and eventually we will use surgery earlier to *prevent* the worst form.

W. D. LITTLE, M.D., (closing): I think no one will deny that the patient is benefitted when foci of infection about the nose and throat are cleaned up, but from the examples that have been presented and a few others that might be presented, I believe it is reasonable to say that in most cases there is no permanent benefit to the goitre symptoms until the goitre itself is attacked.

The article by Hertzler in which he says he believes that colloid goitre, adenomatous goitre, and exophthalmic goitre all belong together, agrees pretty well with the belief of Lewis and Rienhoff. I am sure this conception that has been initiated by Rienhoff will help us in explaining and understanding the pictures under the microscope, perhaps more than anything that has yet been presented.

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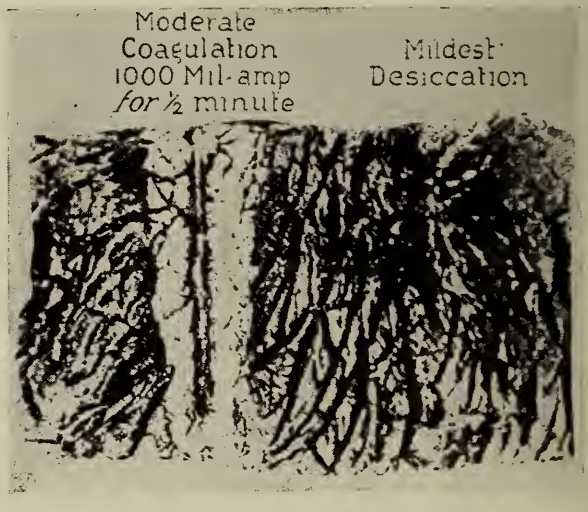
ELECTROSURGERY*

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"Of all means employed in the destruction of pathological tissues the only certain method is that of heat." This dictum of Doyen,[1] the great pioneer high frequency surgeon, is now widely accepted, although his primitive apparatus and technic have both been markedly modified and improved by many illustrious successors, a few of whom, such as Clark,[2] Wyeth,[3] Howard Kelly,[4] Bud Corbus,[5] and Harvey Cushing,[6] may be mentioned as perhaps the most prominent collaborators in this field.

My own experience has been limited to some five hundred cases of malignant and premalignant neoplasms and infectious granulomas seen within the past five years in private and hospital practice, and indicates that:[7]

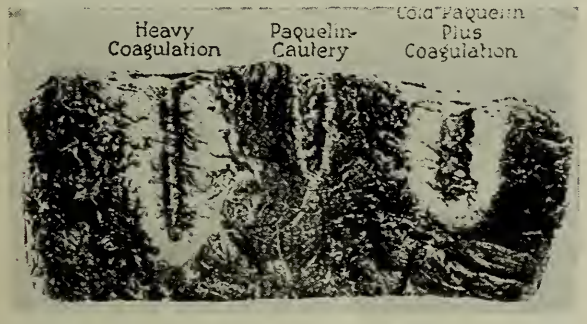
1. The cure of such lesions demands either destruction *in situ* or extirpation *in toto*.
2. The ideal technic, skillfully applied, accomplishes both at the primary operation when either one or more of the following electrothermic methods are correctly employed: electrodessication, electrocoagulation and electrothermic excision.



1A. Reproduction of a piece of meat treated by endothermy, to illustrate dessication and coagulation. On the right a pinpoint area has been dessicated. On the left 1000 ma. applied for half a minute have resulted in moderate coagulation.

Electrodessication, first described by W. L. Clark, is uniterminal electrothermic destruction of superficial tissue. It is far superior to fulguration, from which it differs only in the method of application of the active electrode, since the needle point should be placed almost if not quite in contact with the tissues to be destroyed, rather than held away from the lesion and thus showering its surface with carbonizing sparks. The latter often insulate the subjacent portion of the neoplasm and either failure or even disastrous irritation may occur. In this manner a previously benign lesion may become hyperplastic and result fatally. I

have seen this occur in the inadequate treatment of melanoma. Such malpractice has naturally engendered a widespread distrust among both the profession and the laity in the "electric needle" and not only cast discredit on what should be a perfectly reliable and scientific treatment for superficial lesions, but also prevents the establishment of a simple but efficient prophylaxis against cancer of the skin and readily accessible mucous membranes. A procedure which can be performed quickly and easily in the office, either with or without an anesthetic, which is attended by a minimum of expense, inconvenience, discomfort and scar should recommend itself readily. When, in addition thereto, the agent used is one which sterilizes the lesion, if already infected, and which possesses such wide flexibility as to permit of dessication of a corneal ulcer (in experienced hands) or of a lesion over the nasolacrimal apparatus without endangering their function, and yet again may be varied instantly so as to produce sufficient current concentration to destroy bone, or yet again to excise quickly and bloodlessly large masses of soft tissues—such an agent is too powerful and too



1B. Meat treated by heavier current. Note depth of heavy coagulation at left. In center a Paquelin cautery, heated to a red heat, penetrated the meat at this point and was kept going for half a minute. The effect is merely a surface burn. At the right the Paquelin applicator was thrust cold into the meat and then given 1000 ma. for the same length of time, by attaching one pole of the bi-polar current. Note depth of coagulation.

valuable to be entrusted to unskilled individuals and be brought by them into unmerited discredit.

The histopathology of electrodessication may be described as dehydration or mummification of the tissue cells due to the development within the tissues themselves of a rise of temperature, produced by the conversion of the electrical energy into thermal energy, a process governed by many variable factors such as specific resistance of the tissues to the passage of the current, and the current density. The latter factor varies with voltage, amperage, frequency or rate of oscillation, and method of application. The smaller the electrode, the greater the resistance and the greater the heat—and *vice versa.* The operator must be familiar with all these factors, and vary them instantly in accordance with the anatomy, physiology and pathology associated with each lesion.

Electrocoagulation, or biterminally applied destructive endothermy, is characterized histologically by more marked nuclear changes than in dessication. The tissues immediately adjacent to the active electrode are almost instantly and thoroughly "cooked," cell outline is entirely lost and the protoplasm is condensed into a shapeless coagulum, termed condensation necrosis. If a needle electrode is used and about 1000 milliamperes be passed for about thirty seconds into a mass of flesh (Fig. 1A; after Wyeth), zone of gray coagulum will form for a distance of about one-half centimeter in all directions from the edge of the needle (which, by the way, remains perfectly cold, the temperature being produced by conversive heat within the tissues). Complete cell destruction occurs in the zone next the needle, but in the outermost portions of the coagulated area the cell outlines are faintly present, and in the adjacent tissues more or less dehydration will occur. Theoret-



Fig. 2A. Mr. T., age sixty.

Squamous celled cancer of scalp and ear. Biopsy positive. Neoplasm resistant to both x-ray and radium. Dessication nine months previously had been failure. Electrothermic excision in office under gas anesthesia. Patient remained ambulatory, with very little discomfort.

ically malignant cells are killed at lower temperatures than normal tissue cells, but for all practical purposes it is best for every operator, whether using electrosurgery or not, to make every effort to circumvalate completely the neoplasm.

Fig. 1B (after Wyeth) demonstrates the superior thermopenetration of a high frequency current biterminally applied to ordinary conductive heat as administered through a Paquelin cautery. This may or may not be advantageous, depending

upon the time of application. There is no question, however, as to the greater flexibility and general applicability of the high frequency methods. End results are better, cosmetic appearance is better, recurrences are less likely after the use of the various forms of electrothermic excision, rather than by the use of conductive heating instruments. The latter are more apt to produce an insulating charring which either defeats the purpose of the operation or demands much prolonged application as to be objectionable.

Electrothermic excision may be done with either the undamped or the ordinary damped high frequency current. The former current is of very high frequency, in fact of almost sustained oscillations, and may be produced by radiotrons or by variocouplers. The apparatus is sometimes designated as the "radio knife," and again by others as the electrothermic scalpel. When the needle point

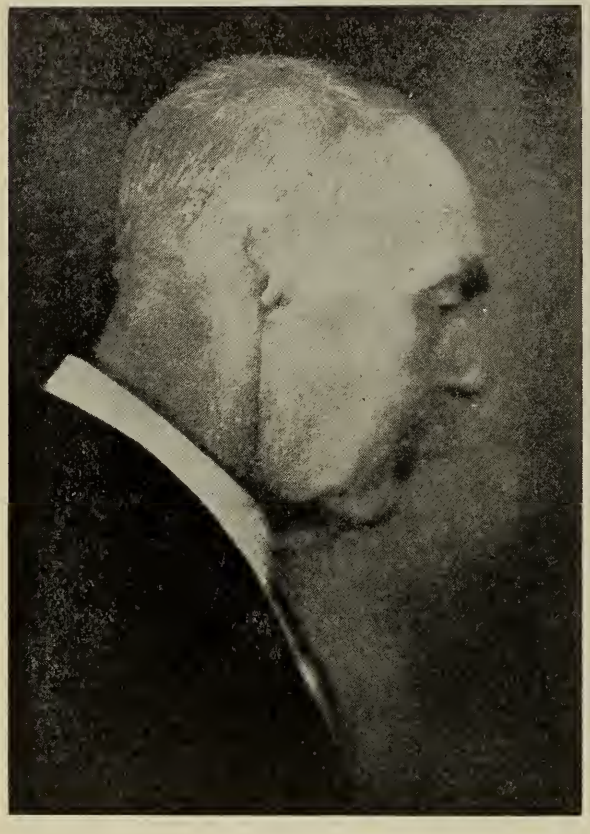


Fig. 2B.—Mr. T.

Three months after electrothermic excision of ear. Complete wound healing, without skin graft.

of the "acusector," as it is termed by Howard Kelly, passes through the tissues rapidly, molecular division occurs with a minimum of electrocoagulation of the adjacent wound edges. Such a wound may often be closed and primary union follow. It is, however, obvious that in this case there is little real advantage over the knife, except in the matter of hemostasis and sterilization of the wound by the cutting agent. When dealing with malignancy, it seems advantageous to use an excising agent which will coagulate beyond the excised zone. It is true that such a wound cannot be closed, and likewise that much more scar tissue will form, perhaps even keloid, but these are matters of secondary importance in fighting cancer. On the other hand, if the neoplasm is only mildly malignant, the uniterminal dessicating current with its lack of scar sequela should be the agent of choice.

It is possible, however, to obtain electrothermic excision with the ordinary damped currents. When used uniterminally, the highest voltage and the smallest, sharpest needle point must be employed, and the machine must be grounded. My prefer-



3A—Mr. E., age sixty.

Recurrent carcinoma of lip. Constant smoker. Previous operation. V-type excision two years previously. Electrodessication, local anesthetic in the office.

ence is also for a very high frequency, over a million if possible, since these currents obey the usual electrical laws of high frequency currents passing through conductors, the higher the frequency the greater the "skin effect," *i. e.*, the more superficial is the destructive agent. If biterminal electrothermic excision be desired, due to the greater thermopenetration, it is better to use a bistury pointed active electrode. Insert this into the tissues, and allow the current to pass (using a suitable foot or hand switch) until the tissues about the needle turn white, thus coagulating an area of about one centimeter. Do not continue the current too long, otherwise sparking will occur, the tissues will become charred and stick to the active electrode. The latter may now be passed in any

direction desired, provided it does not go beyond the coagulated zone; otherwise patent blood vessels will be opened and the operation greatly hindered. Very few machines at the present time are constructed to enable the operator to work under water or in a pool of blood and pus. Since the whole idea of the electrothermic method is to concentrate the heat within a small area, so as to make it destructive, it is evident that the presence of a large amount of a perfect conductor like blood simply dissipates the electrical energy, and no destructive heat is produced.

After having mastered the technic of production of the three electrothermic methods, it is easy to apply them in accordance with the proper indications. For example, if superficial destruction is

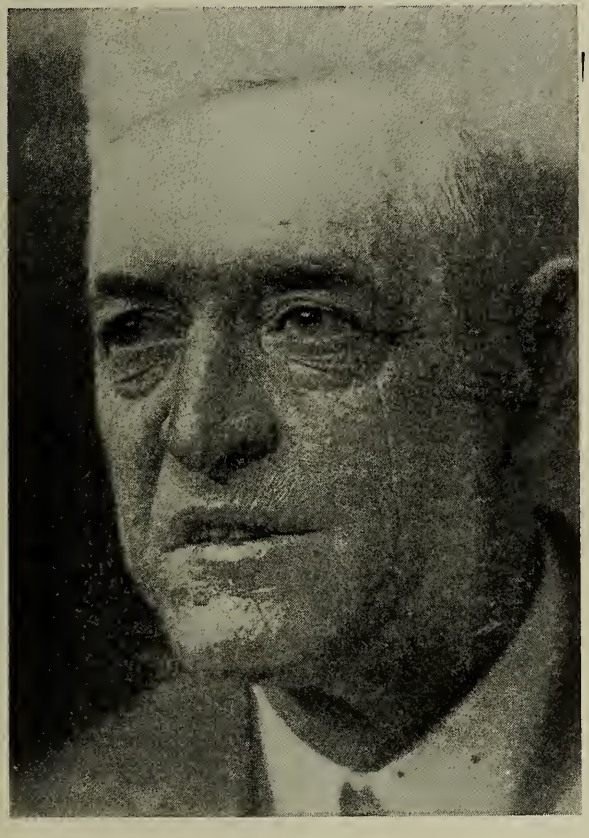


Fig. 3B—Mr. E

Smooth, flexible scar, four weeks after dessication. Reports no recurrence eight months later.

all that is necessary, or desired, such as in premalignant neoplasms of all kinds and in most any location, *e. g.*, verrucæ, nevi, lupus vulgaris, lupus erythematosis, tuberculous sinuses, furuncle, rodent ulcer, leukoplakia and superficial infections of the skin, chancroidal ulcers, cervical erosions, urethral caruncle and a host of other lesions which occasionally are resistant to the usual medicinal and surgical regimen, electrodessication is often brilliantly applicable. This is especially true in regions where for some reason scar tissue is to be avoided at all costs. If on the other hand the lesion is more fungating, of more hyperplastic type, and where scar tissue formation is of secondary importance, electrocoagulation with or without excision is preferable. Unless excision is feasible, my practice is first to coagulate thoroughly around and beneath the lesion, then curette away all necrotic material and then coagulate again one or more times until satisfied that all the diseased tissue has been removed. This practice is more radical than that often advised, and sometimes necessitates ligation of large vessels, and the severance of ducts or nerves, but in the presence of cancer such a course is obligatory. If the malignancy is destroyed and removed, the wounds usually heal with surprisingly little scar. If skin grafting is necessary, they usually "take" well. In stimulation of wound healing, in combating infection and keloid, the water-cooled quartz light has been very valuable. It is even possible to excise electrothermically a small keloid and prevent its reformation by the use of pressure radiation of the granulations through a quartz prism. Electrocoagulation is the agency of choice in accessible malignancy, large condylomata, and carbuncle. I have used it in cancer of the nose, ear, eyelid, vulva, cervix, breast, lip, cheek and extremities. Results in a series of one hundred cases, followed one to three years, were as follows: two deaths in cases already having general metastases, and nine recurrences, five of which have been subsequently reoperated with apparent success. The method is, however, too new to base any positive conclusions, other than the obvious advantage of using some technic which will both destroy *in situ* and excise *in toto*.

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HEALTH WORK IN THE PUBLIC SCHOOLS*

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GARY

A resume of some of the health work carried on in the public schools at Gary, Indiana, is the purpose of this paper. It will include a brief description of the Medical Department and some of its accomplishments.

In this department there are two physicians, eight teachers of health and hygiene (nurses), four clerks, two dentists, three hygienists, one sight-saving teacher, and one oral deaf teacher. The budget for 1927-28 was $24,279.53, or $1.45

*Presented before the general meeting of the annual session of the Indiana State Medical Association at the Gary session, September, 1928.

per pupil, 32 cents below the average of $1.74 for cities of its size having inspection in the United States. The doctors, half the nurses, and the dental people work forty-eight weeks—forty weeks of the regular school and eight weeks of summer school.

When a school reaches an enrollment of two thousand pupils, a nurse is assigned to that building and an office provided. The nurse is on hand the week before the opening of school in the fall to meet the parents and new pupils who are being enrolled at that time. She explains the working of the department. A record is made of name, address, place and date of birth, nationality, also history of past illness of the new pupils. The nurse talks about tests and immunization, and about small-pox vaccination. She advises revaccination at least every five years to test immunity. The nurse then weighs the child, tests its vision. looks at its hair, and if she finds nits or pediculosis, instructs the mother in the use of "Derbac" soap and comb for quick relief, or in the use of coal oil and vinegar, if the mother prefers.

In the initial inspection last year of 13,171 grade pupils, one hundred forty-six such cases were found. In one school in 1919-20 there was a pediculosis case rate of 9.8 with a loss of 40.5 days per 1000 pupils, this has been steadily reduced to 1.6 cases and a loss of 1.3 days per 1000 pupils in 1927-28. In this school five years out of ten have shown no cases, and no time lost on account of impetigo.

If the young child has a strabismus or marked eye defect, the mother is asked to return for a conference with the school physician or to visit the family physician or an oculist.

These are but a few of the advantages that come from the early contact of the nurse with the mother and child.

When school starts the first work is an inspection of all pupils not exempt. This is done by the nurses. All suspicious cases are referred to an accompanying physician. The initial inspection of 13,171 grade pupils in September, 1927, led to the exclusion of one hundred ninety-six pupils.

During the past school year 77,918 pupils were admitted by the nurses after illness. These pupils lost 141,552 days. One thousand three hundred nineteen pupils referred by the nurses to school doctors were excluded. One hundred seventy-one had chicken-pox, four had small-pox, twenty-one measles, twenty-seven scarlet fever, and one thousand ninety-six were excluded for other causes. Five thousand two hundred eighty-three pupils were excused to go home on account of appearing or claiming to be ill. Three thousand two hundred fifty-six were given first aid. Two thousand one hundred fifty-six minor conditions were treated.

In 30,900 pupils enrolled at Emerson School, 15,058 pupils were out of school offering sickness as an excuse during the past year. They lost 26,456½ days. The average duration of the illnesses was 1.75 days. Only 1,368, or nine per cent of these reported that they had a doctor.

In conjunction with the physical education teachers, early in the year the nurses weighed and took the height of the pupils, giving a duplicate card to the pupil. We found that 2,524, or fifteen per cent, of 16,319 pupils were more than ten per cent underweight, and 533, or three and two-tenths per cent, were twenty per cent or more overweight. The standard used was the Wood-Baldwin second revised edition. We have on hand the third revision for use this year.

Lists were made and the underweight pupils were given physcial examinations. In many instances physical defects were corrected. These pupils were weighed several times during the year, and many pupils made satisfactory gains.

VISION

In a special study of eight thousand three hundred sixty-three pupils it was found that three hundred ninety-six or four and seven-tenths per cent had visual defects in one eye sufficient to warrant the recommendation for an examination by a specialist; and three hundred fifty-one, or four and two-tenths per cent, had visual defects to that extent in both eyes. Not all of these people are in need of glasses, but other children, undiscovered by the method employed, would probably bring this number of children needing glasses or treatment to this number. Seven hundred three, or eight and four-tenths per cent of this group, were wearing glasses.

We were fortunate in procuring the services of two oculists, who came to school and made thorough examinations of one hundred sixty-seven eye cases. From these examinations it was determined that there was a need for at least one sight-saving class, and the organization of such a class has been undertaken for pupils below the seventh grade. The department, with the aid of teachers, principals, and at times outside agencies, obtained glasses for over three hundred pupils last year. In most instances payment was made by the parents. In one district, the nurse, with the help of the assistant principal and a school visitor, succeeded in getting parents to supply glasses for fifteen pupils during summer school.

HEARING TESTS

In the spring of 1927, a 4A Graybar audiometer for the testing of hearing by groups was purchased by the Board of Education and put into use. Since that time 18,265 hearing tests have been given resulting in 1,624 pupils showing hearing loss in one ear sufficient to need attention, and eight hundred seventy-one showing hearing loss in both ears to the degree that special treatment was recommended.

These tests are not regarded as infallible tests of hearing impairment, but they do indicate that

the individual, from the third grade up, who cannot pass the test satisfactorily is in need of some special examination to determine the reason for the failure.

Two hundred seventy-six hearing graphs have been made with a 2A Audiometer. Besides this work, our department has been assisted by Gary aurists who have kindly examined any special cases referred to them; in some instances coming to the schools and examining a considerable number of pupils.

A large enough number of children with hearing defects sufficient to impede their progress in normal classes has been found to warrant procuring a special teacher for the hard of hearing. This teacher's duties is to assist these children in developing a good speech; to give to those needing it, instruction in lip reading; and to plan with the regular teachers a program best suited to the child.

MEDICAL EXAMINATION OF TEACHERS

In 1925 a blank form for a medical examination of all new teachers was prepared and has been in use since. It is similar to one used by a standard insurance company. Since that time all new teachers have been required to meet the requirements for a standard insurance policy. The purpose of such an examination is obvious to a physician. It has been beneficial to the applicants and to the schools. A periodic health examination is available to teachers who desire it. An increasing number are taking advantage of this.

The school physicians are the sole judges of the physical fitness of candidates for the high school athletic teams. They also examine the R. O. T. C. candidates and excuse pupils from physical education. The school physicians are glad to excuse pupils convalescing from acute illness, afflicted with chronic conditions, malnutrition, or any condition where a short school program is desired, from all unnecessary work. In most instances the child's school day can be reduced to three hours per day. However, the Gary school tries to provide for the child, for seven or eight hours at school, a well-balanced life consisting of work, study, and play, and at no greater expense than the short school programs of the traditional school.

CRIPPLED CHILDREN

An orthopedic surgeon gives freely of his time at school for special conferences with parents about crippled children or by examination in his office, with reports. Other surgeons have given their time for this purpose. When recommendations are made regarding treatment of these cases, and operations, appliances, or treatments cannot be procured by the family, arrangements are made whereby the family may procure a loan which will enable them to have the matter attended to or needed treatment procured from one of several agencies. The physically handicapped pupil often becomes a problem case in the school, and to interest an organization such as the Elks, Rotary, or Kiwanians in the child has a fine influence and makes better citizens of the children, as well as affording pleasure to the members of the club.

We are now engaged in a special study of our need for a special room for crippled children. Where possible, it is our feeling that these pupils are better off with normal children.

TUBERCULOSIS

Children unable to procure proper medical attention are often referred to the Lake County Tuberculosis Sanitorium clinic for examination. Ninety-two children have been examined during the past school year. The reports received from these examinations show the following conditions:

Number with hilum T. B.	6
Number with Pulmonary T. B.	3
Number Suspicious T. B.	9
T. B. Negative	65

SUMMER SCHOOL PHYSICAL EXAMINATIONS

An examination of 1,836 pupils during summer school of 1928 showed that 72 per cent had vaccination scars; 306, or 17 per cent, had had tonsillectomies; 70, or 3.6 per cent, were wearing glasses; 317, or 17 per cent, were under weight; 44 were over weight, and 167, or 9 per cent, had visual defects. Notices were sent about the following conditions:

Teeth	644
Tonsils	329
Nasal obstruction	98
Defective vision	167
Diseased eyes	7
Skin	14
Heart	7
Speech	2
Pediculosis	42
Hernia	2
Scalp	11

DENTAL WORK

The Gary Dental Society appointed a committee to act as an advisory committee in the development of a dental service to pupils below grade 5A. The pupils pay one dollar each into a trust fund for dental services. This is paid as a part of the fee known as book rental, paid by all pupils who desire the school to supply books and supplies.

Two dentists, especially trained in children's dentistry, three full-time dental hygienists, and two clerks constitute the dental corps.

Dental work for children is greatly needed. This is neglected by parents and not desired by most dentists. Much good has resulted from the school work, and a very great improvement in the cleanliness of our children's mouths has come about. The dental workers are equipped with portable outfits and go from school to school. A request

is sent by a parent before other work than cleaning and examinations is done. About 75 per cent of the parents have asked for the services of the school dentists.

A permanent office is maintained for use on Saturday mornings to serve any child in need of emergency or special treatment. This work is in its second year.

Health education is carried on by the use of motion pictures, lectures, plays, and demonstrations in the Auditorium. The nature study classes devote one hour a week to the subject. The pupils in the art department make posters. Three hundred posters were made and entered in a dental health poster contest last year.

Two supervisors of physical education devote all their time to directing forty-five teachers of physical education and four club workers who not only provide a program of exercises, games, and recreation, for the day school pupils, but also direct similar activities for Saturday, Sunday afternoons, and evenings.

IMMUNIZATION WORK

At the request of the Gary physicians, an immunization program against scarlet fever, diphtheria, and small-pox was undertaken by the public schools, for the purpose of educating the community and protecting it against epidemics.

After eighteen months the work was discussed by the physicians, and the Board of Education was asked to continue the work.

In this work the Gary Health Department has co-operated by furnishing material for the small-pox and diphtheria work and by giving official and professional support.

Doctors George and Gladys Dick have directed and supplied all the test and immunizing materials used in the scarlet fever work.

Table No. I

RESULT OF SCHICK TESTS

	1927-28		Total since 1924	
Positive	684	52 %	3627	48.8%
Combined	48	3.6%	66	0.8%
Negative	546	44.4%	3393	45.7%
Pseudo	40		331	4.4%
Total read	1318		7417	
Absent for reading	88		876	
Reading disregarded on account of material	237		302	
Total given	1643		8595	

One thousand three hundred eighteen Schick tests were read last year showing fifty-two per cent to be positive. Out of 7,417 tests read since 1924, 3,627, or 48 per cent were positive.

Table No. II

SCHICK RETESTS

	1927-28		Total since 1924	
Positive	296	29.6%	693	28.1%
Combined	98	9.8%	98	3.9%
Negative	485	48.4%	1548	58.8%
Pseudo	123	12.2%	123	5 %
Total read	1002		2462	
Absent for reading	91		91	
Reading disregarded on account of material	140		140	
Total given	1233		2693	

Thirty-nine per cent plus of 1,002 retests given last year were still positive, and 791 were still positive of 2,462 retests given after immunization since 1924, being 32 per cent.

The necessity for group testing is still apparent on account of impotent test material as shown by our having to disregard 377 tests, or 13 per cent, for this reason during the past year. See tables I and II.

Four thousand eight hundred eighty-six doses of diphtheria toxin-antitoxin were given during the year. During the early part of the year the anti-toxin used was made from horse serum and later from goat serum.

First doses of diphtheria toxin-antitoxin were given to 1,736, second doses to 1,633, and third doses to 1,517. Since 1924 the total number of doses of diphtheria toxin-antitoxin given has been 14,004.

We were anxious to try out diphtheria toxoid and procured enough to immunize one hundred twenty-five children from one of the biological manufacturers who had a license from the Hygienic Laboratory but who was not marketing the preparation at that time.

Two doses three weeks apart were given to Schick positive children under eight years of age without test as to their susceptibility to the toxoid. Reactions reported were as follows (See Table No. III).

In the above, the age of the children in both groups, in Table No. III, and the time of administration was about the same. It will be noted that, in this series, the reactions following toxoid are apparently somewhat less frequent and no more severe than reactions following doses of toxin-antitoxin in which the anti-toxin is prepared from goat's serum.

No detailed record was kept of reactions occurring after doses of toxin-antitoxin given earlier in the year, at which time we were using material in which the anti-toxin was prepared from horse serum. It is our impression, however, that reactions following these doses were more frequent and severe than those occurring in either of the above tabulations.

Sixty-seven of those given toxoid were re-tested after three months, with 45, or 67 per cent, negative. This is equal to three doses of toxin-antitoxin.

Table No. III

REACTIONS

	First dose Toxoid		Second dose Toxoid		Diph. T. A.	
Total number given	119		112		95	
Local reaction in which redness and swelling was less than 2"x2"	66	56.5%	63	57.2%	55	57%
Local reaction in which redness and swelling was more than 2"x2"	4	3.3%	14	13.5%	15	16%
Headache	1	.8%	2	1.7%	7	8%
Nausea	2	1.6%	3	2.6%	1	1%
Emesis	3	2.5%	3	2.6%	0	
Abdominal cramps	0		0		1	1%
No reaction	41	35.3%	26	24.1%	15	16%

Retests given three months later on sixty-seven of the above forty-five, or about sixty-seven per cent, to be Schick negative. This is about the same per cent rendered negative by three doses of T. A. T. in our experience.

Table No. IV

SUMMARY OF DICK TESTS GIVEN

	Primary 1927-28		Retests after S. F. Toxin Since 1924	
Positive	1100	52.2%	303	16 %
Slightly positive	186	8.8%	289	15.2%
Negative	821	39 %	1306	69 %
Total read	2107		1898	
Absent for reading	133		115	
Total given	2240		2013	
Total primary and retests given	4253			

Table No. V

SCARLET FEVER TOXIN

Number of doses started	1216	
Number doses completed	951	78%
Incomplete series	265	22%
Refused	22	8%
Absence	243	92%

	No. Doses
First doses	1216
Second doses	1188
Third doses	1122
Fourth doses	1072
Fifth doses	951
Sixth doses	76
Total	5625

Table No. VI

REACTIONS AFTER DOSES OF SCARLET FEVER TOXIN

	Strength of Dose 500	2000	8000	25000	80000	Ttl.
Total number doses given	1216	1188	1122	1072	1027	5625
Local reaction, sore arm	502	499	447	372	215	2035
Nausea	25	21	44	29	17	136
Headache	24	36	45	31	12	148
Emesis	11	24	51	43	41	170
Rash and fever	1	2		1	1	5
General malaise	3	1	5	3	2	14
Muscular reaction			3	5	5	13
Abdominal cramps		1		2		3
Fever	2	4			1	7
Stiffness in joints			1	1		2
Total	568	588	596	487	294	2533

Table No. VII

DICK RETESTS—SCHOOL YEAR—1927 TO 1928

Summary of Retests Done Within Two to Three Weeks After Completion of Doses.

Doses used in this group: 500, 2000, 8000, 25000, 80000, s. t. d.

Tested after 5 doses:	Negative	588	81.7%
	Sl. Positive	108	15.0%
	Positive	24	3.3%
	Total	720	
Tested after 4 doses:	Negative	54	70.1%
	Sl. Positive	16	20.8%
	Positive	7	9.1%
	Total	77	
Tested after 3 doses:	Negative	11	35.5%
	Sl. Positive	11	35.5%
	Positive	9	29.0%
	Total	31	
Tested after 2 doses:	Negative	3	27.3%
	Sl. Positive	0	0
	Positive	8	72.7%
	Total	11	
Tested after 1 dose:	Negative	2	33.3%
	Sl. Positive	1	16.7%
	Positive	3	50 %
	Total	6	
Grand total		845	

Table No. VIII

Summary of Retests Done on Children Who Were Still Positive Two Weeks After Last Dose and Were Given One or More Additional Doses and Again Retested.

Positive or slightly positive after five doses and given one additional dose of 80,000. Result of final retest: 66.

Negative	43	65.2%
Sl. Positive	17	25.8%
Positive	6	9.0%

Positive or slightly positive after four doses and given one additional dose of 80,000. Result of final retest: 14.

Negative	9	64.3%
Sl. Positive	4	28.6%
Positive	1	7.1%

Positive or slightly positive after five doses and given two additional doses of 40,000. Result of final retest: 20.

Negative	9	45%
Sl. Positive	8	40%
Positive	3	15%

Total	100
Grand total	1677

Note: The remaining two hundred twenty-one retests done during the school year represent a miscellaneous group tested at varying periods after doses of scarlet fever toxin. No attempt has been made to classify these.

Table No. IX

Summary of Dick retests given during school year of 1927-28 to those who had been retested previously after earlier series of scarlet fever toxin.

		Interval Between Tests. Under 6 mo.		6 mo. to 1 yr.		1 yr. to 2 yrs.		2 to 3 yrs.		3 to 4 yrs.	
Total dosage received S. T. D.	Negative to Negative	3	75%	22	91 %	10	100 %	0		0	
	Negative to S. Positive	0		1	4.5%	0		0		0	
	Negative to Positive	1	25%	1	4.5%	0		0		0	
Over 100,000	S. Positive to Negative	6		3		0		0		0	
	Positive to Negative	3		1		1		0		0	
	Positive to Positive	5		5		1		0		0	
	Total	18		33		12		0		0	
	Negative to Negative	8	80%	91	72.2%	132	81 %	3	75 %	0	
	Negative to S. Positive	1	10%	23	18.3%	24	14.7%	1	25 %	0	
50,000 to 100,000	Negative to Positive	1	10%	12	9.5%	7	4.3%	0		0	
	S. Positive to Negative	3		1		2		1		0	
	Positive to Negative	9		10		2		0		0	
	Positive to Positive	6		26		6		0		0	
	Total	28		163		173		5		0	
	Negative to Negative	1	100%	18	56.3%	26	47.4%	46	62.2%	2	100 %
	Negative to S. Positive	0		8	25 %	8	14.5%	16	21.6%	0	
5,000 to 50,000	Negative to Positive	0		6	18.7%	21	38.1%	12	16.2%	0	
	S. Positive to Negative	3		2		4		2		0	
	Positive to Negative	1		2		0		1		0	
	Positive to Positive	5		12		8		3		2	
	Total	10		48		67		80		4	
	Negative to Negative	0		0		5	83.3%	13	52 %	12	38.7%
	Negative to S. Positive	0		1	50 %	1	16.7%	4	16 %	1	3.2%
5,000 or under	Negative to Positive	0		1	50 %	0		8	32 %	18	58.1%
	S. Positive to Negative	0		2		0		3		1	
	Positive to Negative	0		0		0		0		0	
	Positive to Positive	2		4		1		12		2	
	Total	2		8		7		40		34	
	Grand total	732									

Table No. X

SCARLET FEVER CASES

Total cases of scarlet fever reported to Gary Board of Health, September, 1927, to June, 1928, were:

Negative Dick at former tests	2
Positive Dick	1
No Dick test	66
Total cases of scarlet fever	69

Total number of cases of scarlet fever reported during September to June of previous years, shown in relation to school census:

School Year	Cases of S. F.	School Census
1919 to 1920	114	13,447
1920 to 1921	87	15,331
1921 to 1922	38	15,217
1922 to 1923	214	16,664
1923 to 1924	386	18,438
1924 to 1925	121	20,472
1925 to 1926	113	23,210
1926 to 1927	160	24,852
1927 to 1928	69	26,681

Table No. XI

Table showing total number of cases of diphtheria and scarlet fever, 1923 to 1928, by months, Gary, Indiana.

	1923		1924		1925		1926		1927		1928	
	S.F.	D.	S.F.	D.	S.F.	D.	S.F.	D.	S.F.	D.	S.F.	D.
January	10	3	49	20	11	3	12	13	22	8	6	2
February	11	4	72	19	17	5	5	4	38	5	4	5
March	16	1	55	8	20	1	11	2	24	4	10	3
April	21	0	40	0	15	1	11	4	11	3	3	0
May	70	0	35	8	11	2	17	2	7	1	3	0
June	31	5	20	4	6	2	6	1	5	1	8	1
July	9	0	9	2	5	5	5	0	2	2	4	2
Aug.	2	1	2	1	4	4	0	0	1	0	1	2
Sept.	7	2	9	8	3	3	10	3	5	1		
Oct.	19	22	9	12	17	11	8	15	2	4		
Nov.	43	36	8	5	8	8	22	18	12	4		
Dec.	45	24	8	5	23	10	13	12	8	5		
Total	284	98	316	95	140	55	120	74	137	38		

Table No. XII

No. cases of scarlet fever per 1000 children of school age, Gary, for nine years:

1919-20	8.5	1925-26	4.8
1920-21	5.6	1926-27	6.8
1921-22	2.3	1927-28	2.5
1922-23	12.8	Mean	5.8
1923-24	20.9	Average	7.7
1924-25	5.8	Average past 4 years	5.0

Sixty-five per cent decrease of number of cases.

CASES OF INTEREST

1. Boy, age twelve. Negative after three doses of S. F. T. in 1924. No retest since. Developed scarlet fever in September, 1927. Very mild case.

2. Girl, age three. Developed scarlet fever in January, 1928. Three school children in same family living at home and none developed scarlet fever. All have been tested previously. Two showed primary negative tests and the other was negative after three doses in 1925.

3. Girl, age eleven. Dick positive 7/22/24. Given 300, 600, 1200 S. T. D. Retest 12/16/24 positive. Given 200 S. T. D. 2/5/25. Retest 5/12/25 negative. Developed scarlet fever 3/8/28.

4. Girl, age nine. Dick positive 7/22/24. Given 300, 600, 1200 S. T. D. Retest 12/16/24 positive. Given 3000 S. T. D. 2/24/25. Retest 5/12/25 pseudo. Retest 5/10/26 slightly positive; retest 5/4/27 positive. Given 500, 200, 8000, 25000, 50000 S. T. D. 6/3/27. Retest 6/20/27 probably positive. Given 60000 S. T. D. 6/21/27. Not retested since. Developed very mild attack of scarlet fever in March, 1928. Slight rash, little desquamation. Retest 5/28/28, 10x10 mm. Positive.

SMALL-POX VACCINATIONS

During the last two years we have been using the Leake method of vaccination and have attempted interpreting according to whether reactions were successful, immune, or vaccinoid.

Vaccinations are done at school only upon request signed by a parent. We advise revaccination to test for immunity every five years at least.

We cleanse the skin with acetone, and apply fresh vaccine that has been kept cold in an ice box (freezing does not hurt it.) With sterile needle thirty punctures are made with the needle in a horizontal position to the arm. (We refuse to vaccinate on the leg.) We then wipe the arm with sterile gauze, apply no dressing, give the patient printed instructions which direct that no dressings or shields or tight clothing be worn over the site of vaccination.

With potent vaccine there are no failures if the vaccination be properly done. One of the above named reactions should follow. If vaccinations are done in this manner, we rarely see a badly inflamed arm as was frequent with the scratch method, and the resulting scars are not extensive. In fact, many can not be found by persons not accustomed to looking for them.

From September, 1919, to September, 1924, the average number of pupils out with smallpox was two and six-tenths per thousand with a loss of one hundred twenty-four days per thousand pupils per year. Since September, 1924, the average has been one per thousand pupils out with the disease and the days lost has been twenty-one and two-tenth per thousand pupils per year.

The vaccination of pupils by school physicians has lessened the cases of smallpox and the days lost from school therefrom; the number of cases out of school on account of vaccinations; and the number of days lost therefrom.

During the past school year one thousand two hundred two primary vaccinations and seven hundred and one revaccinations were done at school.

CONCLUSIONS

Two doses of diphtheria toxoid appear to be as effective as three doses of toxin-antitoxin in immunizing against diphtheria, as evidenced by a negative Schick test.

Three doses of toxoid or five doses of toxin-antitoxin should be given instead of the two and three doses respectively, as now generally employed. This would result in immunizing ninety per cent or more of those susceptible, while with the present dosage of commercial preparations used by us we get only sixty to eighty per cent immunized.

For children under eight years of age we would prefer three doses of diphtheria toxoid because of less severe and fewer reactions.

The family physician should immunize the young children, those under two years, to smallpox and diphtheria, and if they do not do so, the health department should provide the machinery. If both of these fail, then outside welfare agencies can not be blamed for providing the service that will lessen sickness and save lives.

While the highest death rate from diphtheria is among the pre-school age children, and to wipe this out will require the immunization of the babies, yet in our experience the diphtheria and scarlet fever case rates and death rates have both been reduced by immunization of the school age group.

The physicians of a community should agree if possible on the scarlet fever program to be carried out. Preparations not approved by the scarlet fever commission should not be advised.

The immunization against diphtheria and scarlet fever can be given to normal children between two and six years of age without primary skin tests, and the family physician could arrange to do his testing in groups, or the testing could be turned over to the health department or the school physicians.

The schools should not be expected to carry the burden of immunizations longer than to educate the community of the value of the procedure.

Medical inspection is valuable to a school because it enables it to protect its pupils and teachers from vermin, skin troubles, epidemic and infectious disease. In Gary we never close a room or school on account of any disease outbreak. The continuing of schools and searching for the person suffering from the disease or for the carrier who is responsible for the spread of it is the preferred method. By co-operating with a good health department, epidemics of the severe diseases can be prevented or ended.

Besides its first aid service, the medical department searches out children physically and mentally handicapped. The advisory position it occupies with the parent, after the school examination, often keeps a family in the hands of competent medical men or returns them to such. The entire department is constantly explaining the need for every family to have a dependable family physician and the importance of relying upon him for all things regarding their medical needs.

Discussion

John E. Yarling, M.D. (Peru): It is the end results that interest us, the reactions following such conditions as scarlet fever. We get very severe ones in our country.

John C. Burkle, M.D. (Lafayette): I think this is a problem that goes into the home and is just as vital as the patriotic problem. Of course these things do not work perfectly, as the Doctor says, but I think the biggest problem is to get the system started in the schools through the state. Dr. Nesbit has been fortunate in starting in a new city and starting right. It is a process of education, as he told us, and his idea of the nurse being on the job a day or two before school opens to meet the mothers and children is a tremendous point in the spreading of this education.

I would like to ask Dr. Nesbit whether there has been any antitoxin used in the treatment of scarlet fever.

Another point is that we must get these children of pre-school age because they are the ones that many times die of diphtheria and scarlet fever. Then the child is immunized and is all right when he starts to school.

O. B. Nesbit, M.D. (closing): Answering Dr. Burkle, we do not have an opportunity to treat these conditions and therefore have no experience with antitoxins of any kind. There has been some scarlet fever antitoxin used here. Some of the physicians think they have had some results from it, but as with diphtheria, the antitoxin must be used early to get the greatest results.

LOCAL ANESTHESIA AGENTS

Edward G. Martin, Detroit (*Journal A. M. A.*, Aug. 25, 1928), believes that procaine is not very poisonous in the usual dosage. If a man (weighing 168 pounds, or 76 Kg.) could be compared to a dog, he could take 340 grains (22 Gm.) of procaine in ten percent solution and be saved from death by the intravenous administration of 120 grains (7.8 Gm.) of soluble barbital in divided doses. In man with an average dose of 20 grains (1.3 Gm.) of procaine in a one or two percent solution, five or ten grains (0.3 or 0.6 Gm.) of soluble barbital dissolved in 120 minims (8 cc.) of water can be administered intravenously with the expectation of controlling toxic symptoms. He believes that an idiosyncrasy is responsible for most toxic exhibitions. Ten grains (0.6 Gm.) of soluble barbital by mouth given about one hour before operation will prevent the development of serious toxic symptoms in most instances. Investigation and experimentation in this field are far from complete or conclusive, and an independent and exhaustive study of the different salts of barbituric acid should be made to determine their individual efficiency in the detoxication of local anesthetics.

FISSURES OF NOSE

Richard L. Sutton, Kansas City, Missouri (*Journal A. M. A.*, Aug. 25, 1928), describes lesions which occur at the anterior angle of the opening of the nose, and, while scarcely perceptible to the eye of the examiner, are very persistent, and give rise to considerable pain and discomfort. Not infrequently there is a secondary, streptococcic involvement, which may cause slight fever and some intermittent redness of the tip of the organ. Dryness of the nasal mucosa and rosacea probably are provocative factors, but why the condition is almost wholly limited, at least in my experience, to middle-aged women, he does not know. The most effective agent is a needle-pointed electric cautery. With this modern "microbrenner" the raw surface, previously put on the stretch by means of a nasal speculum, is carefully "ironed" out. Afterward, a dressing of ointment of yellow mercuric oxide (two percent) is applied. As a rule, relief is prompt and permanent.

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EDITORIALS

THE PREVENTION OF BLINDNESS

Much has been said and written concerning the prevention of blindness, and the salient points have been brought to the attention of medical profession and public alike. Special emphasis has been placed upon the prevention of industrial injuries, and much has been accomplished in that direction through the co-operation of employers of labor who have been quite willing to adopt safety devices and establish rules of conduct for employees with the idea of preventing eye injuries. Likewise the prevention of blindness from ophthalmia neonatorum has been preached with such vigor that our lawmakers have co-operated by enacting laws requiring the use of preventive measures, and at the present time few states are without statutes requiring the Credé preventive treatment at all births. Occasionally a physician, and more often a midwife, either through ignorance or carelessness neglects to use the Credé preventive treatment, and a case of gonorrheal ophthalmia develops, with perhaps loss of vision, but such instances are rather rare now. There are, however, many people who go blind from glaucoma as a result not only of ignorance on the part of the patient but perhaps on the part of opticians, general physicians, or even some so-called oculists who fail to recognize the disease. The cases of simple or noncongestive glaucoma not infrequently go blind without ever having had any attempts put forth to check the ravages of the disease. The trouble is one of middle age and comes on at about the time when glasses should be worn for reading, and if the patient consults an optician he seldom if ever gets anything but a pair of glasses, and no recommendation to see a well-trained oculist in order to detect any pathologic changes that may have occurred. There may have been such prodromal symptoms as transient blurring of vision, an uneasiness about the eye, or halos about lights, but as the central vision remains good and glasses improve reading, little or no attention is given to the symptoms which are mistaken for the need of glasses. Even the apparent necessity for the frequent changing in the lenses does not seem to arouse suspicion, and the gradual contraction of the field of vision and other symptoms and manifestations do not interest the family physician who may think that because the eye is not red and does not pain there cannot be much the matter with it excepting the need of appropriate glasses. When the optician fails to bring up the vision with lenses, and such failure is bound to occur with the inevitable impairment of central vision, the patient not infrequently is told that he has a beginning cataract which should not be molested until it is "ripe" and then operation will restore vision. Finally, after all or nearly all of the central vision has been lost as a result of the continued intraocular tension, the patient usually falls into the hands of a trained oculist who at once recognizes the trouble but is obliged to inform the patient that it is too late to accomplish any favorable results. The eye has become blind without any evidence of discomfort or congestion, and ignorance on the part of those who have had the patient under observation is responsible for the neglect in seeking skilled aid. Were it not that the well-trained oculist sees many such cases there would be no occasion for criticism, but when patients, innocent themselves of having done wrong, have insidiously but nevertheless surely become blind while lulled into security by advice from an ignorant physician and a still more ignorant optician, the matter becomes of sufficient gravity to justify an effort to correct the evil. The first place to begin is with the family physician who usually knows something about the onset of impairment of vision in his patients even if not directly consulted concerning such manifestations. If the family physician fulfills his duty to the patient he will advise consultation with an oculist and not accept the dictum of an optician or other spectacle vender to the effect that glasses and glasses only are required for failing vision and some of the indefinite symptoms that usually go with beginning simple glaucoma. The clinical picture may be indefinite until cleared up by the use of the tonometer, perimeter, and ophthalmoscope, but the well-trained oculist will employ these aids intelligently and discover the trouble in its incipiency and recommend the appropriate treatment. To him diagnosis offers few obstacles, and it is little short of criminal for others, untrained in the diagnosis and treatment of eye afflictions, to assume the responsibility of caring for patients suffering from such an insidious disease as simple glaucoma without realizing the nature of the disease and that a continuation of the error means certain blindness for the patient.

CHRISTIAN SCIENTISTS ASK FOR CO-OPERATION OF MEDICAL MEN

There never has been a more inconsistent, cruel and unjust belief and practice than that of the orthodox Christian Scientist healer. Unnecessary suffering and preventable deaths at their hands have occurred to an alarming extent if the whole truth were known. Christian Science has been

such a business-like organization, and has had so many ramifications in all walks of life, that it has been able to prevent or suppress much of the antagonism that would have been encountered had any other group of people, not covered by the mantle of so-called religion, been as guilty. Not only has there been a continuous and far-reaching propaganda, distributed through newspapers and publications of various kinds throughout the world, but all open criticism of Christian Science teachings and practice, no matter where uttered, has met with retaliation on the part of the paid representatives of the Christian Science church, under the name of "Publication Committee."

There is much evidence to the effect that the Christian Science faith is losing adherents, and of course as much is to be expected, for one would have to be very much unbalanced mentally if he did not, at some time or other, find ample evidence to prove the absurdity and falseness of much of the Christian Science faith and practice. Unfortunately many Christian Scientists have been ashamed to admit error, and in consequence, in a rather hypocritical way, professed allegiance to the Christian Science faith while inwardly doubting its teachings and secretly deviating from its practices. That the mental attitude of a person may have much to do with his physical well-being is unquestioned. That has been recognized by the medical profession for centuries. All that is good in Christian Science, insofar as it pertains to the alleviation or cure of physical illness, gets due credit from the medical profession, but the inconsistent, illogical and deceptive teachings and practices of the Christian Scientists, as pertains to etiology and cure of all diseased conditions of body or mind, are frowned upon.

The Christian Scientists have their internal strifes, even to the point of carrying their differences to court, and just now we are interested in the belief of what seems to be a branch of the Christian Scientists, in which it is stated boldly that there is some virtue in the work of the members of the regular medical profession, even to the extent of admitting the beneficial effects of drugs where indicated. They even go so far as to court a friendly cooperation with the medical profession in efforts to advance world health. In other words, they seem to admit frankly that there is a place for medicine as well as a place for religion in the treatment of bodily ills, and that religion and medicine must work hand in hand, to which we might add that we are quite willing to let those of any religious belief take care of the religious end of the physical, mental or spiritual ills of humanity as long as they do not interfere with or hamper the work of the members of the medical profession. Anyway, the letter from the editor of the *Christian Science Watchman,* published in the Correspondence Department of this month's issue of The Journal, is an illuminating concession on the part of some of the Christian Scientists, and we hope that every reader of The Journal will take occasion to read the letter.

WOMAN'S AUXILIARY

Again we wish to say that we welcome the organization of the Woman's Auxiliary of the Indiana State Medical Association, and The Journal will aid the auxiliary in every possible way to assist in upholding everything pertaining to scientific medicine. We sincerely hope that the sponsors for the Auxiliary will not consider that the enterprise is doing its whole duty if it has as its principal function the stimulation of social activity, and the glorification of various prominent members. There is a real place for the Auxiliary, and much constructive work can be done if an effort is put forth to help increase the usefulness of the medical profession and aid in creating and maintaining a better economic status for the individual physician. Quackery thrives on every hand, and there are many benevolent and socialistic schemes proposed by thoughtless individuals that have to do with some phase of medical education or practice and which ought to be suppressed. Every city, town and hamlet has its women's clubs, and those clubs are breeding places for many irrational and inconsistent ideas concerning progress of one kind or another in which medicine and surgery have a more or less prominent part, and it is these clubs that tolerate the pleas of pseudo-medical cults and where the sponsors for various forms of socialistic medicine find willing listeners and converts. Probably all of the members of the Woman's Auxiliary belong to one or more of these women's organizations, and the influence of these Auxiliary women should be put forth to correct some of the impressions and errors creeping into the deliberations of women's clubs, sometimes unintentionally and sometimes by intent. In other words, the women belonging to the Auxiliary ought to be openly and publicly standing for all of the high ideals and purposes of their husbands, and they ought to be joining hands with their husbands in suppressing the evils that are injurious to scientific medicine as well as to the public. More power to the right hand of the Auxiliary if it does this!

PHYSICIANS SHOULD BE INTERESTED IN POLITICS

Medical men are taking a greater interest in politics than ever before, but that interest should be increased to the point where the opinion or advice of the medical profession as a whole will be heeded by politicians and law-makers. That this is indicated is best told by the action of one of the representatives who served in the last Indiana legislature. He admitted that he was in favor of upholding scientific medicine, but he

frankly stated that in his neighborhood a few medical pretenders who took an active interest in politics and were good mixers had such an influence that from a political standpoint he had to side with them, and particularly as the reputable medical men in his vicinity were apathetic and made no attempt to have their influence felt in politics. It should be remembered that the average legislator does not vote as his conscience dictates but as he thinks he should vote in order to retain popularity or continuance in office. Therefore, when the members of the regular medical profession, whose opinion should be respected, take an active interest in politics, then and then only will the politicians sit up and take notice. In one county the medical men were openly opposed to a certain candidate for the legislature because he was known to be favorable to the interests of the cults. He was elected in spite of the work of the members of the regular medical profession, and subsequently it was argued by one of the physicians that in view of the activity taken in the campaign the regular medical profession could expect no concessions or favors from the representative from that particular district. To all of this we answer that they could not have expected anything from their representative even if the members of the medical profession had *not* taken any interest in the campaign, for as a friend of the cults he would continue a friend of the cults under any and all circumstances. A very large majority of the politicians are looking for votes, and if those opposed to scientific medicine are putting forth their best efforts to win recognition and favor, it is a sure bet that they are going to succeed over an apathetic medical profession that does nothing to arouse sentiment and create tangible sympathy for scientific medicine. It is not necessary to stoop to questionable methods in order to bring about a healthy sentiment among legislators concerning legislation that is necessary for the support of scientific medicine and the protection of public health. The trouble with medical men is that they are not unified in purpose as they should be, nor do they become active in the support of means and measures so necessary for their own salvation as well as the salvation of the public insofar as medical education and practice is concerned.

TRAVELING EXPENSES ARE DEDUCTIBLE

Traveling expenses incurred by physicians in attending meetings of medical associations are deductible in the computation of their federal income taxes. The Commissioner of Internal Revenue has erred in denying the deductibility of such expenses. The Board of Tax Appeals made this decision, October 2, in passing on the appeal of Dr. Cecil M. Jack, of Decatur, Illinois. The decision becomes final at the expiration of six months from its promulgation unless an appeal is taken to the courts before that time. The commissioner did not appeal, however, when the Board of Tax Appeals rendered similar decisions against him in favor of ministers and of chemists, in cases identical in every essential circumstance with the present case. In those decisions the commissioner officially acquiesced, without waiting for six months to expire, and there seems to be no reason why he should follow a different course now. Acquiescence seems more probable, too, since the board, in promulgating its decision in the present case, cited as precedents the very cases in which the commissioner had acquiesced, and repudiated as a precedent a decision of the board by which the commissioner undertook to justify his course. In that case, the board pointed out, it was necessary for the board to uphold the commissioner's denial of the physician's claim of the right to deduct traveling expenses, because the physician had not submitted proofs of the amounts expended. The only discoverable result that would follow an appeal by the commissioner is added expense and trouble to the taxpayer and to the government, an additional case to clog the court calendar, and, pending a decision by the court, many thousands of payments unlawfully exacted of physicians under the guise of taxation, to be added to the tens of thousands of such payments already exacted, all of which the government may be called on to refund.

Since the Commissioner of Internal Revenue first denied to physicians their right to deduct traveling expenses, in 1922, the medical profession has paid probably as much as a half million dollars into the treasury, to avoid unlawful demands by the commissioner, the distraint of property, and suits. Subject to certain limitations on the time within which claims for refunds must be filed, all of this money will be repayable to the physician who paid it, if the courts are not called on within six months to reverse the decision of the Board of Tax Appeals and if on appeal they sustain the decision of the board.

Application for refunds may be filed without waiting for any further official action in the case. Claims for refunds for the tax years 1924 and 1925 must be made within four years from the date of payment; for the tax years 1926 and 1927, within three years; and for the tax year 1928, within two years. Unfortunately, in many individual cases the amounts repayable are probably so small that the physician will not feel justified in going to the trouble and expense of making a claim, and in many cases it will be difficult at this late date to produce adequate legal proof of the exact amounts paid for railroad fares, Pullman accommodations, hotel accommodations, meals, and other allowable expenses. Applications for refunds must be made on the special form provided for that purpose, copies of which can

be obtained from the local collector of internal revenue. A separate application must be made for each year for which a refund is claimed. Every application must show that it is based on the decision of the Board of Tax Appeals in *Jack* v. *Commissioner of Internal Revenue*. Applications must be filed with the collector of internal revenue within whose district the deductible money was paid.—*Jour. A. M. A.*, October 27.

EDITORIAL NOTES

Dear Doctor:

The Journal and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in The Journal, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask The Journal about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want The Journal to serve *you*.

The postgraduate medical courses conducted by the medical department of the University of Michigan and carried out in every populous community in Michigan seem to be a great success. Why doesn't Indiana adopt some such plan instead of carrying on postgraduate work in a sort of spasmodic fashion in isolated localities? We have had a lot of talk about this matter, but so far there has been little action.

It has been charged that none of the cultists voted for Smith for president, and for the very good and sufficient reason that Smith always has supported scientific medicine from start to finish. We have just been wondering if the cultists got any comfort from Hoover. It would seem that the cultists thought they were choosing the lesser of two evils, though we are inclined to believe that Hoover is just as much a supporter of scientific medicine as anyone can be.

Well, the president of the Indiana State Board of Health, who is not a member of a reputable medical society and who hobnobs with advertising quacks, got a nice piece of advertising out of the fact that he presided at a meeting of state health officers held at Gary in October. He was appointed to his position on the state board of health by Governor Jackson, so—enough said! However, some effort should be put forth to have our State Board of Health composed of reputable physicians.

The prevention of scarlet fever, diphtheria, and typhoid by immunization is a job for the private physician. We quite agree with the editorial comment on this matter in the September issue of the *Wisconsin Medical Journal* which says that "unless the private physician will realize and assume his responsibilities in modern preventive medicine, he may expect public health agencies, that now offer not only immunization but medical service and therapeutics as well, to carry him on to state medicine."

Some of the manufacturers of concentrated and malted milks are taking advantage of the fact that at the present time some localities are suffering from typhoid due to consumption of infected milk, and are recommending that the concentrated or malted milk preparations be substituted. The suggestion is not without merit, for the public can better afford to pay a little more for one of the prepared milk products than to take chances on a milk supply that is not properly supervised in production and marketing.

Many dairymen object to rigid inspection and requirements covering the producing and marketing of dairy products. In the interests of the public health all food supplies should be guaranteed as reasonably pure and uncontaminated, and if the responsibility in the matter of milk products is to be shifted to the dairyman then we ought to inflict severe penalties upon him if he is guilty of negligence or of deviation from established rules of health and sanitation in the production and marketing of dairy products.

We are reminded of the uncertainty of life when we stop to think that the profession has lost a number of prominent members during the last few months, and none of them could be considered old men. Among them may be mentioned Doctors Thomas C. Kennedy, of Indianapolis, C. C. Terry, of South Bend, C. F. Neu, of Indianapolis. Charles G. Beall, of Fort Wayne, Frank A. Morrison, Indianapolis, Samuel E. Smith, Indianapolis, Albert M. Cole, Indianapolis, George T. Johnson, Terre Haute, and James A. Work, Sr., of Elkhart.

Last month we commented on the fact that one advertising himself "Dr. Alfred Ernest George Hall, dean of the American Academy of Psychological Research," was arrested in Indianapolis on a charge of vagrancy and with being a fugitive from justice, inasmuch as he was wanted by the police department in Chicago. Hall, who has a number of titles printed after his name, including that of "M.D.," is not licensed to practice medicine in Indiana. Through a newspaper interview he now asserts that he is going to bring into court the A. M. A. and all others who have traduced him. We would like to remind him that he must not forget the police officers in several Canadian and American cities.

THE editor of the *Christian Science Watchman*, published in Washington, D. C., has sent us a communication which we publish in the Correspondence Department of this number of THE JOURNAL. He says that he represents the independent minority movement in Christian Science that is trying to bring a new spirit of sanity and common sense into the practice of mental healing. We quite agree with him that the average Christian Scientist needs a little common sense as well as honesty and displays little of it! However, we are willing to give this minority movement in Christian Science sympathetic encouragement, for if it is carried to fruition it means doing away with a major portion of the greatest exhibition of hypocrisy of the age.

IN previous numbers of THE JOURNAL, and quite recently in the daily newspapers of Indianapolis, reference has been made to the activities of "Doctor" S. Edgar Bond, of Richmond, who bears a rather unsavory reputation from the standpoint of ethical physicians. Unfortunately the name has been confused with that of Dr. Charles S. Bond, of Richmond, an ex-president of the Indiana State Medical Association and a physician of high standing in his community as well as the profession at large. It is quite possible that S. Edgar Bond may profit by being mistaken for Charles S. Bond, but the latter should not be expected to carry the burden of the other fellow nor be classed with the other fellow merely because of the repetition of the last name.

EVIDENTLY the Denicotinized Tobacco Company has felt the effect of the criticisms aimed at it by the medical press, for now we are receiving circulars which say, in effect, that it is quite possible that medical men may be mistaken when they say that there is no such thing as a really denicotinized tobacco. Well, all we have to say is that we have tried some of the most popular denicotinized tobacco, and the one that is most extensively advertised, and found it little or no different than the ordinary mild tobacco purchased in any cigar store. Denicotinized tobacco, like caffeinless coffee, is a delusion and a snare. You cannot "smoke it to your heart's content and with content to your heart," as advertised, and feel that the result is any different than the result secured from smoking ordinary tobacco.

WE are in a position to note the antagonism exhibited by the secretary of the State Board of Health to the proposal on the part of the laboratory men of the state that some effort be put forth to stop State Laboratory abuses. The secretary asks the medical men to offer a plan to correct evils which he has created. As a matter of fact he can stop abuses of the State Laboratory inside of twenty-four hours if he cares to do so. We do not believe that he desires to stop it. In fact there is developing considerable evidence to prove that he is nursing state medicine ideas. Well, perhaps in the near future the Indiana State Medical Association will have some influence in settling some of the problems that are of vital concern to the profession as well as the public insofar as medical service on the part of the state is concerned.

"DAVY" CROCKETT, as he is familiarly known, but who professionally goes under the name of Dr. Frank S. Crockett, of Lafayette, Indiana, says that whenever THE JOURNAL mentions the fact that he, as chairman of the Committee on Civic and Industrial Relations of the Indiana State Medical Association, will act as an arbitrator in the disputes of physicians who are having trouble with employers of labor or insurance carriers concerning bills rendered for services in industrial cases, there is at once an influx of business. Well, there is one way in which the Indiana State Medical Association can serve its members and that is through the good offices of "Davy," so again we urge those who are having difficulty in collecting their accounts for industrial services to get in touch with him. We might say, too, that "it pays to advertise."

WE believe that in municipal, county and state politics it is a good policy to vote for men and not for political parties. No doubt we must have men who will support vital issues, but we have had our trust betrayed so many times that we get skeptical when it comes to a question of voting a party ticket, whether Democratic or Republican. In the recent election there were some candidates for office whom we beliee can be trusted just about as far as you can throw a cat by the tail. Some of these men will have much to do with legislation of interest to medical men and for that reason we, as physicians, should have thought well before we cast our ballots for such persons. Some of these candidates for office were known to be antagonistic to everything of interest to physicians, and yet we know that there are some physicians who are so steeped in party fealty that they walked into the voting booth and voted a straight party ticket no matter who the party representatives were. We sincerely hope that a majority of the Indiana physicians were independent in action and voted for the man rather than the party, though it does not look that way.

OF all the rotten advertising that has appeared within recent years that of a well-known cigar company which says "Men who guard their health smoke cigars" takes the prize for misrepresentation. They quote a so-called physical culture expert who says that "when a man switches from other forms of tobacco to cigars his wind improves, he is more steady, and he has more endurance

and so tires less easily than before." There probably isn't a well-trained physician who will not say that tobacco is injurious to the average individual, and more injurious to some than others. He will say as much even if he himself smokes, for he knows it is the truth, so why not put the seal of disapproval upon all of this false argument concerning the harmless effect of tobacco whether it is in the form of "toasted" cigarettes, or cigars, advertised to improve voice, increase vitality and do away with "that tired feeling" if smoked regularly.

Persistence wins! For several years physicians have been battling for the right to deduct from their income taxes the amount spent as expenses while attending medical meetings and postgraduate courses. For some unaccountable reason the commissioner of internal revenue persisted in his refusal to permit physicians to do what followers of other professions and vocations were privileged to do, and in consequence the expense in attending medical meetings, which should be classed as a part of the operating expense of business, could not be deducted from income tax returns. The legal bureau of the A. M. A., supported by efforts on the part of the various state medical organizations, finally has secured a ruling from the Board of Tax Appeals which sets aside the arbitrary ruling of the commissioner, and in consequence every physician will be entitled to deduct his expenses in attending medical meetings from tax returns filed for 1928. Thus an injustice has been remedied.

So far this year the automobile accidents for Indiana are one hundred per month more than they were for the year 1927. This does not mean more speed or more reckless driving, but rather an increase of accidents due to an increase in the number of drivers. Accidents may occur as a result of reckless driving, but we have known many accidents to occur to various persons who are considered careful drivers and not guilty of excessive speed. At present we permit the feeble-minded, the poor-sighted, the crippled and the under-age to drive over our city streets and country roads, with automobiles every one of which in this day and age may be considered high-powered and capable of making high speed. However, it is not speed which causes these misfits to have accidents. Instead of establishing speed limits we ought to establish driving tests, and insist upon the physical examination and licensing of every person who drives an automobile. In no other way can we lessen the number of accidents which seem to be mounting year by year with the increase in traffic.

If there are any county medical societies in Indiana that desire to put on a full day of postgraduate conferences, we suggest that they write Tom Hendricks, the executive secretary of the Indiana State Medical Association, and learn how to do it. The plan proposed contemplates having from six to ten prominent clinicians and teachers present the program. Practical subjects are selected, and the latest ideas concerning the subjects are presented. The talks, which may be illustrated by stereopticon or chalk drawings, are confined to thirty or forty minutes, and the balance of an hour's time is devoted to answering questions from members of the audience. At the conclusion of the hour the speaker is politely but firmly requested to give way to the next speaker on the program, so that there will be no over-lapping or curtailment of the assigned time of the various speakers. The men selected to give these postgraduate conferences are considered very capable in giving a comprehensive and yet concise presentation of the subjects assigned. Some of them come from Indiana, and some come from outside of the state. Don't all speak at once for the course!

Every reputable and intelligent physician in Indiana should be able to administer the antirabic treatment, and there is no reason why he should not do so. At present these rabies cases go to Indianapolis to be treated by the State Board of Health, and the question arises as to whether the patients are indigent or not. Due to the increase in rabies in Indiana the number of cases applying for antirabic treatment has increased until the work has become a burden to the Board of Health, to say nothing of being an enormous expense to the taxpayers. There is no good reason why this state medicine feature should be continued, and if the State Board of Health is anxious to stop it, an effective way will be found in the adoption of a rule that suspected rabies cases must be treated by the physician in the community in which the case arises, and that when indicated the antirabic serum will be furnished by the state free of all expense. It is a foregone conclusion that the treatment will be administered free by any physician if charity is indicated. On the other hand, there is no reason why payment for the treatment should not be made by those able to pay.

The average physician is willing to fight if he finds his toes stepped upon, but he isn't willing to turn a hand to help someone else who is being imposed upon. As an illustration we point to the physician in a city in the central part of the state who complained bitterly because he lost a fee for two or three tonsillectomies that went to the Riley Hospital in Indianapolis where the operations were done gratuitously after being certified by the home authorities as entitled to charity even though there was sufficient proof to show that they were not entitled to such consideration. Objection was raised to the free service on the part of the state, but the doctor making

the objection sees nothing wrong in having his laboratory work done at the state laboratories without charge, and collecting a fee from his patient for the same. If the State Board of Health takes a few more steps in the direction of state medicine there is going to go up a mighty wail from a lot of physicians who at the present time are closing their eyes to many inconsistencies and injustices in the way of furnishing free medical services of one kind or another whether deserved or not.

IT is reported that sixty million dollars will be utilized in the completion of a medical center in New York City. The units of the medical center consist of the medical and dental departments of Columbia University, the de Lamar Institute of Public Health, the New York State Psychiatric Institute and Hospital, the Presbyterian Hospital and its School of Nursing, the Scroll Urological Clinic, the Harkness Private Pavilion, the Neurological Institute of New York, the Babies' Hospital of New York, the Sloane Hospital for Women, and the Vanderbilt Clinic. Theoretically, it would seem that there is no problem connected with medical and surgical research that cannot be worked out when, figuratively speaking, there is no limit to the facilities offered for the advancement of the theory and practice of medicine. From a philanthropic standpoint the medical center offers almost unlimited opportunity for deserved charity and benevolence. It will require very careful supervision if abuses do not creep in. From a sociological standpoint the center offers unusual opportunities for giving help to suffering humanity and laying a foundation for improved service in the future.

WE know it is a standing joke that in the waiting room of the average physician can be found dirty magazines of an old vintage, offered as reading matter for patients who have to wait for the doctor. What a pity it is that the average doctor does not make an attempt to have his offices and especially the waiting room look attractive. We have published a series of articles on the decoration of the physician's office, and we hope that those articles have put ideas into the heads of a lot of physicians who are careless and indifferent about the appearance of their offices to say nothing of being careless and indifferent about their own personal appearance. It is not necessary to spend a good deal of money in order to have clean and attractive offices, and there is no excuse for having papers and magazines of from one to ten years of age on the reception room table. Subscribe for a few *good* newspapers and magazines and put them in your reception room immediately upon their arrival. Furthermore, adopt such furnishings as will make the offices attractive without appearing gaudy, and above everything else have the offices *clean*. Nothing detracts from a physician's reputation any more than a dirty office and a careless personal appearance.

THE head of the Anti-Saloon League in Indiana was charged with meddling in politics and putting forth an effort to influence or intimidate the courts. Much to our surprise he finally was convicted, and sentenced to a fine and imprisonment. A vigilant and fearless attorney general made the sentence stick up to the last minute, and the head of the Anti-Saloon League packed a few necessary articles in a small hand bag and headed for prison but, as we predicted, a governor who has the name of being mixed up in all kinds of rotten politics and who barely escaped conviction himself, was on hand with a pardon. The question now will be raised, is there any person or collection of persons in the state of Indiana who has any well-grounded respect for law? The law-abiding citizen is a rarity, and the law-breaking citizen finds no difficulty in escaping the penalties of the law. What occurs in politics and business occurs in the medical profession. Dangerous medical pretenders practice in Indiana without let or hindrance. If, perchance, one of them is haled into court, he manages to escape the penalty of the law and then laughs to think how easy it is to circumvent legal restrictions enacted to prevent him from preying upon the sick and suffering and to protect the public from injustice.

AN interesting feature of the recent annual convention of the American Public Health Association, held in Chicago last month, was an exhibit of five traveling health departments or railroad cars, equipped so that they can be rushed to the scene of disaster or epidemic, or take care of health service from a central point to isolated districts. These cars were stationed on the Illinois Central terminal tracks and were visited by many of those attending the convention. The automobile health equipment, on view in one of the parks, also attracted much attention. In all probability the automobile health equipment is the one that will be used largely by states, whereas the railroad cars equipped for public health work, should be operated by the United States Public Health Service, as they are more adapted to widespread disaster that cannot be handled so efficiently by states or local communities. There would not have been quite so much complaint about the delay in furnishing aid to stricken territory in Florida a few weeks ago had the government furnished money and traveling health departments as an aid to the Red Cross. There is no reason why a few benevolent and charitable institutions and individuals should be called upon for the aid that should be given by our national government.

The *Illinois Medical Journal* for September, 1928, says that among the hospitals and similar enterprises catering to the general public yet man-

aged for the immediate benefit of the organizations controlling them, especial attention is called to the hospital connected with the University of Michigan and the Cornell University Clinic. Articles are quoted from *American Medicine* and the *People's Health* which seem to prove the contention that the medical profession cannot continue in existence and compete with endowed institutions or university hospitals which are, in reality, organizations politically controlled and supported by authorized general taxation. In fact, as the *Illinois Medical Journal* says, it is the unfair competition of state and endowed hospitals which makes it difficult for medical men as individuals to exist and earn a living income. It is argued that there is a pressing need for institutions which can furnish modern, scientific medical service at moderate cost. However, the organized medical profession in any community can do this and conduct the enterprise on a basis that will not pauperize the people and will not offer the unfair competition that now occurs through the rendering of such service by state or endowed hospitals.

At the Gary session of the Indiana State Medical Association a resolution was offered to the House of Delegates in which certain abuses of the State Laboratories were cited and the State Board of Health was asked to correct the abuses in the interest of fairness to the medical profession as well as in the interests of the public that is, in a certain sense, being pauperized by too much free service that is not justified. The resolution brought forth some spirited discussion, and still more spirited discussion outside of the meeting. It certainly looks as though some of the actions and practices of the State Board of Health have aroused the wrath of many members of the regular medical profession of the state, and this wrath is not appeased by suggestions on the part of the State Board of Health that remedies be offered to correct evils of the Board's own creation. The controversy, when boiled down, resolves itself into a question of whether the Board of Health shall practice medicine or not, and the question must be settled right now before more trouble for the State Board of Health as well as the medical profession occurs. The laws creating and sustaining the State Board of Health do not contemplate that the Board shall enter into or in any way compete with the private practice of medicine.

The U. S. Public Health Service announces that since 1912 it has been studying and combating the scourge of trachoma which is prevalent in certain states, particularly areas in Kentucky, Tennessee, Missouri and Arkansas. Clinics and small hospitals have been established where persons suffering from this disease may receive skilled treatment. In addition to the treatment of cases, considerable study has been conducted directed toward an investigation of the cause of this condition. In a recently published article it has been stated that progress is being made in the study of the bacteriological factors which appear to enter into the cause of this disease. Scientific opinion varies somewhat as to the real cause of trachoma. Some authorities claim that it is due to bacteria. By some it is stated that diet or perhaps other factors influence its cause and spread. Recent studies by the Public Health Service seem to indicate that in all probability certain organisms or "bodies" which have been known for some time, are bacterial in character and they, no doubt, originate from bacteria. The fact of their presence in a considerable percentage of trachoma cases is an indication that they may be of some significance in the causation of the disease, but the question cannot be answered definitely as yet.

In a newspaper interview in St. Louis (Associated Press), Bernarr Macfadden, of physical culture notoriety, claims to be responsible for the banishment of the corset as well as for the adoption of the one-piece bathing suit for women. We are surprised that he has said nothing about being responsible for putting the women's dresses above the knees for street wear, and for the general lack of modesty so apparent among some women. However, he makes up for all this by stating in the interview that he now hopes to introduce nudity in place of the one-piece bathing suit, and tops the whole thing off by saying that in general we are too prudish in not wishing to sanction nudity in such public places as the bathing beaches. Perhaps if we adopt the customs of some of the South Sea Islanders and go around without any clothes there will be a great economic saving for certain seasons of the year, and possibly health will be better in consequence, but we are not so sure that it will be an improvement upon morals. However, we are experimentnig with companionate marriage, free love, and some other social evils, so why not try nakedness and put Lady Godiva down as a piker. The females who possess Venus-like forms and secretly desire to expose their physical charms to the public gaze should crown Macfadden as leader and king. We believe that a goodly number of the female sex, in the United States at least, possess enough innate sense of modesty and propriety to shun any such innovations as those proposed by Macfadden.

We fail to understand why the various Better Business Bureaus of Indiana have not taken some steps toward suppressing much of the fraudulent and misleading medical advertising that can be found in many of the newspapers throughout the state. Through the influence of Better Business Bureaus and members of the medical profession some of the prominent newspapers in other states absolutely refuse

to accept medical advertising of any description, and they draw a hard and fast line for the reason that practically all of the medical advertising is misleading even if not grossly fraudulent. However, in Indiana, with the exception of the *Indianapolis News* and possibly one or two other newspapers of less circulation, the rankest medical frauds find recognition in the public press of the state. Another thing which surprises us is that the merchants who indirectly are seriously injured by money taken out of their various communities in payment of medical frauds, do not rise up in wrath and refuse to patronize newspapers that carry misleading medical advertising. They put a stop to misleading trade advertising which hurts them no more than misleading medical advertising. Perhaps one reason why the merchants have not taken an interest in the matter is because the reputable members of the medical profession have said nothing to them about the subject. At all events if the medical profession is going to support Better Business Bureaus, then those Better Business Bureaus ought to consider the question of putting forth some effort to suppress misleading medical advertising in the lay press.

DR. ALFRED ERNEST GEORGE HALL, billed as a psychologist and dean of the American Academy of Psychological Research, and self-styled authority on health, love, sex, happiness and personality, was arrested by the police in Indianapolis on October 15, and held on a charge of vagrancy and with being a fugitive from justice. This is the "bird" with the police record who has been tied up with quack psychology schemes and various physicians and chiropractors, and with Abrams and Koch disciples and other individuals of the same kidney. Hall was driven out of Canada when his career was known. The Better Business Bureau of Indianapolis acted promptly and in consequence Hall is waiting for extradition to Chicago where the police want him. It is a strange thing that reputable men as newspaper publishers will accept the advertising of such an impostor as Hall proved to be. The very nature of the advertising should brand it as being unworthy of acceptance. While we are on this subject we would like to call the attention of our readers to another blatant advertiser by the name of Dr. R. A. Richardson who has been booked in various Indiana cities to lecture on various subjects which, he says, if followed, will bring health, happiness and prosperity. His opening lecture usually is entitled "Miracles of Life and Living, and Seeing Correctly." It is said that aside from selling his book, which is filled with a lot of inconsistent nonsense, he reaps profit from dupes by giving consultations concerning sexual problems and similar matters. It is expected that a certain number of gullible people will fall for such fellows as Richardson and Hall, but there is no reason why physicians should fall for them.

A NOTORIOUS quack doctor is reputed to have said to some of his assistants, "When you are dealing with patients, if you keep your mouth closed no one will know how dumb you are!" We are reminded of this as a result of a recent experience with a regular practitioner of medicine who has quite a following but whose ability and training do not justify it. His stock in trade is a look as wise as an old owl, but he is careful not to express any opinion or be drawn into any conversation that will expose his ignorance if possible to avoid it. When he is forced to express an opinion he gives evidence of his ignorance. In short, in the practice of medicine he bluffs his way through, but occasionally a patient pushes through his engaging personality and superficial veneer of medical knowledge and discovers the real uneducated and illy trained physician. We have the greatest sympathy and admiration for the man who knows that he is starting out poorly equipped for his life's work, but who has the enterprise and desire to work hard to improve himself. Such a man avails himself of the latest medical books and journals, and sits in the front row at every medical society meeting that he can manage to attend. He is not content to practice medicine with only such superficial education and training as may have been sufficient to secure for him a legal right to practice. We know many such men, as we also know some who though old in the practice of medicine are just as untrustworthy now as they were the first time they announced their readiness to receive patients. Books and medical journals help to give any physician postgraduate instruction, but these should be supplemented by contact with confreres in our medical societies, for exchange of opinions aids in promoting better ideas concerning the alleviation of disease.

UNDER the title, "A Ghastly Record," the Christian Science parent church, from its headquarters in London as well as in Washington, D. C., publishes a circular giving some of the statistics compiled from the official record of vital statistics of the town of Brookline, Massachusetts, showing that 154 persons passed away at the Christian Science Sanitarium, located in Brookline, during the first five years of its existence. The list is not complete and probably for the reason, as intimated in the circular, that the Christian Science Sanitarium authorities have suppressed available information. As an indication of the deception that was practiced, the law was not followed in giving the name of the institution where the deaths occurred, for only the street number is given in a good many cases, just as the record would have been had the death occurred in a private residence. Evidently this was with the idea of creating the belief that deaths at the Christian Science institution are an exceedingly rare event. In other words, the Christian Science authorities concealed the real facts. It is announced that some

of the deaths were real tragedies and others were as gruesome as could be imagined and yet sometimes while the patient was in a death struggle the Sanitarium reported that the patient was "healing" under the Christian Science ministrations. An interesting sidelight is the fact, furnished by the parent church, that while Brookline is the home of three medical hospitals of national reputation, yet all three of those hospitals do not have a combined death rate during five years equivalent to that occurring at the Christian Science Sanitarium. Facts are stubborn things to confront, and for the good of the public as well as suffering humanity, it is fortunate that some Christian Scientists are beginning to be honest with themselves as well as with the public.

In answer to the complaint of the National Grange relative to the country doctor situation, a correspondent of the Illinois Medical Journal says that "the blame should be placed where it belongs, for the farmer has deserted the small town doctor, not the doctor the small town." In the early days when the country doctor was an important factor in any community it took two hours to go twelve miles. Now days the farmer in that community can drive fifty or more miles in the same length of time. In a country community the local doctor often gets nothing but emergency and confinement cases, and such other work as occurs among those too poor to get away. Even some of the confinements go out of town to the nearby city hospitals, and much of the surgery goes out without even consulting the local men. The people are still in the small towns and sickness still is there, but the people and their sickness are on wheels traveling to the big cities. In other words, the farmer has deserted the small town doctor, the doctor has not deserted the farmer.

There is much truth in all that has been said concerning this subject, and yet something may be said on the other side. We would like to repeat the old saying about the beaten path to the door of the man who made the best mouse trap. There are country doctors who render such excellent service that they have attracted patronage not alone from their own community but far distant communities and even neighboring cities. Our criticism of the average country doctor is exactly the same as the criticism of the average city doctor who is stumbling along, trying to make both ends meet, and that is that he fails to render the very best service, either because he is not capable of rendering such service or because he feels that if he devotes more time and attention to his cases he will not be paid adequately for it. On the whole the well-trained, capable and conscientious physician will have no difficulty in acquiring a satisfactory practice in any populous community, whether it be known as a city or a country community, and as a usual thing he will get along more rapidly and better in a country community than he will in a city.

DEATHS

O. E. Druley, M.D., of Anderson, died October 8th, aged sixty years. He was graduated from the Medical College of Ohio, Cincinnati, in 1889.

J. G. Cox, M.D., of Kokomo, died October 7th, aged fifty-nine years. Dr. Cox was graduated from the Medical College of Indiana, Indianapolis, in 1892.

J. T. Laughead, M.D., of Terre Haute, died October 16th, aged seventy-six years. He was graduated from the Medical College of Ohio, Cincinnati, in 1877.

Francis M. Wells, M.D., of Jeffersonville, died September 18th, aged seventy years. Dr. Wells graduated from the University of Louisville, School of Medicine, Louisville, Kentucky, in 1882.

William H. Van Sandt, M.D., of Carbon, died September 30th, aged eighty-eight years. Dr. Van Sandt had retired from the active practice of medicine. He was a graduate of the Indiana Medical College of Indianapolis in 1870.

James P. Burroughs, M.D., of Westport, the oldest physician in Decatur county, died October 16th, aged ninety years. Dr. Burroughs had been an invalid for the past twenty years and had been confined to his home nearly all of that time.

Allen Pierson, M.D., of Spencer, died October 23rd, aged seventy-nine years. Dr. Pierson graduated from the Indiana Medical College Indianapolis, in 1878. He was a member of the Indiana State Medical Association and the American Medical Association, and was secretary of the Owen County Medical Society.

Abram N. Van Ryper, M.D., of New Carlisle, died in South Bend, September 21st, from injuries received in an automobile accident. Dr. Van Ryper was seventy-eight years of age and had been a practicing physician in New Carlisle for the past fifty years. Dr. Van Ryper graduated from the Bennett Medical College, Chicago, in 1876.

Charles C. Terry, M.D., of South Bend, died October 5th, aged sixty-two years. Dr. Terry was an outstanding surgeon of South Bend, having practiced in that city for thirty-four years. Dr. Terry graduated from the University of Illinois College of Medicine, Chicago, in 1889. He was a Fellow of the American College of Surgeons, a member of the St. Joseph County Medical

Society, the Indiana State Medical Association and the American Medical Association.

HARRY M. HOSMER, M.D., of Gary, died October 14th, aged forty-nine years. Dr. Hosmer's death was believed due to the effects of mustard gas to which he was subjected during the World War, during which he served as major in the U. S. Army. He was graduated from the University of Pennsylvania School of Medicine in 1904, and was a member of the Lake County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

MATTHEW S. DENAUT, M.D., of Walkerton, died October 26, aged sixty-five years. Dr. Denaut had been ill for several months. He graduated from Rush Medical College, Chicago, in 1897. He was local surgeon for the B. and O., the Nickel Plate and the New York Central railroads, and for many years was the health officer for Walkerton. He was a member of the St. Joseph County Medical Society, the Indiana State Medical Association and the American Medical Association.

CHARLES F. NEU, M.D., of Indianapolis, died October 10th, aged sixty-two years, in the Methodist Hospital in Indianapolis following an illness of several weeks. Dr. Neu was assistant professor of mental and nervous diseases at the Indiana University School of Medicine. He was a member of the Central Neuropsychiatric Association, the Indianapolis Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association. Dr. Neu was graduated from the University of Western Ontario Medical School, London, in 1894.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

THE trustees of the Irene Byron Sanitarium were hosts to the members of the Fort Wayne Medical Society, October 2nd.

THE Daviess-Martin County Medical Society and associated dentists and guests held a meeting October 11th at Washington, Indiana.

THE Indianapolis Medical Society held its regular meeting October 23rd, with Dr. George L. Clark, of the University of Illinois, as principal speaker.

THE Randolph County Medical Society held a meeting October 8th at Winchester. Dr. B. M. Taylor, of Portland, presented a paper on "Infant Feeding."

DR. JOHN H. WILLIAMS, formerly of Cowan, Indiana, has announced that he has purchased a home in Muncie where he expects to continue the practice of medicine.

B. E. LEMMON, M.D., and family, who recently moved to Indianapolis, returned to Spencer in September, where Dr. Lemmon will continue the practice of medicine.

THE one hundred twenty-second semi-annual meeting of the Union District Medical Association was held at the Westwood Country Club, near Newcastle, October 25th.

THE thirty-ninth annual meeting of the Association of American Medical Colleges was held October 29th, 30th and 31st, in Indianapolis, with headquarters at the Claypool Hotel.

THE Tippecanoe County Medical Society held its regular meeting at Lafayette, October 11th. A clinic on diseases of children was held at St. Elizabeth's Hospital by Dr. Clifford G. Grulee, of Chicago.

THE Muncie Academy of Medicine held its regular meeting at the Hotel Roberts, Muncie, November 6. Dr. Louis R. Effler, of Toledo, presented a paper, his subject being "The Press, the Public and the Physician."

AT the October 16th meeting of the Indianapolis Medical Society, Dr. Albert E. Sterne presented a lantern demonstration on "Cytology and Structural Elements of the Brain Cortex with a New View of Their Significance."

THE Elwood Medical Society, which discontinued its programs during the summer months, resumed its meetings with a dinner at the Kramer Hotel, Elwood, October 17th. Dr. Larue Carter, of Indianapolis, presented an address on "Head Injuries."

THE Northeastern Indiana Academy of Medicine held a meeting at Gawthrop Hotel, Kendallville, October 25th. Following the dinner the sixth lecture of the postgraduate course from the Indiana University School of Medicine was presented by Dr. George Bond, of Indianapolis, whose subject was "Goitre."

THE Seventh District Medical Society held a meeting at Martinsville, October 30th, at the Martinsville Sanitarium. Papers were presented by Doctors M. C. Pitkin, Martinsville; E. Vernon Hahn, Indianapolis; L. Walter Portteus, Frank-

lin; Jewett V. Reed, Indianapolis; O. B. Nesbit, Gary, and O. T. Scamahorn, Pittsboro.

Chas. D. Humes, M.D., Indianapolis, addressed the St. Clair County Medical Society at East St. Louis, Illinois, Wednesday evening, October 4, 1928, on the subject of "The Residue of Encephalitis." He illustrated his talk with motion pictures. During the day Dr. Humes held a clinic at St. Mary's Hospital, East St. Louis.

The Muncie Academy of Medicine held a meeting at the Hotel Roberts, October 2nd. The Academy will meet this season on Tuesday evenings instead of Friday; meetings will be held on the first and second Tuesday and on the fifth Tuesday when there is one. Dr. Lacey L. Shuler, of Indianapolis, talked on the subject, "Orthopedic Surgery in the General Practice of Medicine."

The Indiana University School of Medicine plans this winter to have several eminent orthopedic surgeons give clinics and addresses at the Riley Hospital. The first of these was given by Dr. Edwin Ryerson, of Chicago, October 18th. An operative clinic was held at the Riley Hospital and in the afternoon an address was presented at the Medical School, the subject being "The Treatment of Ununited Fractures."

The regular monthly clinic program of the Welborn Hospital Clinic was held in Evansville, October 17th. A case was reported by Dr. J. Y. Welborn; Dr. J. F. Wynn presented a paper on "Skull Fractures"; Dr. K. T. Meyer talked on "The Radiographic Interpretation of the Dentogram," and a moving picture on "Pulmonary Tuberculosis" was given. A number of physicians from the tri-state territory were in attendance.

The fortieth semi-annual meeting of the Eleventh Indiana Councilor District Medical Association was held at Marion, October 11, with headquarters at the Hotel Spencer. Dr. Louis H. Segar, of Indianapolis, presented a clinic on diseases of children. Dr. Robert M. Moore, of Indianapolis, presented a paper on "Heart Block," and Dr. Miles F. Porter, Jr., of Fort Wayne, presented a paper on "Chronic Arthritis."

Applications will be rated as received until December 29, 1928, for senior medical officer, medical officer, associate medical officer and assistant medical officer for the U. S. Civil Service Commission. Examinations are to fill vacancies occurring in the federal classified civil service throughout the United States. Application blanks and complete information may be obtained from the U. S. Civil Service Commission, Washington, D. C.

The U. S. Civil Service Commission announces open competitive examination for cytologist. Applications must be on file at Washington, D. C., not later than November 28. Examination is to fill a vacancy in the Hygienic Laboratory, U. S. Public Health Service, Washington, D. C., and vacancies occurring in positions requiring similar qualifications. Full information may be obtained from the U. S. Civil Service Commission, Washington, D. C.

Dr. Park Lewis, of Buffalo, New York, vice-president of the National Society for the Prevention of Blindness, was presented the Leslie Dana Medal at St. Louis, October 18th, "for the most outstanding achievements in the prevention of blindness and the conservation of vision" in America. The medal is given through the Missouri Association for the Blind, of which Mr. Leslie Dana is a director, and it is one of the most highly prized marks of recognition in the public health field.

The U. S. Civil Service Commission announces open competitive examinations for occupational therapy aide (arts and crafts); occupational therapy aide (trades and industries); occupational therapy aide (gardening); occupational therapy aide (horticulture and floriculture); occupational therapy pupil aide (arts and crafts; trades and industries); and occupational therapy assistant (trades and industries). Applications will be rated as received by the U. S. Civil Service Commission at Washington, D. C.

Dr. Burton D. Myers, dean of the Indiana University School of Medicine at Bloomington, was elected president of the Association of American Medical Colleges at an executive session of the association held in Indianapolis October 30. Dr. Fred C. Zapffe, of the Northwestern University School of Medicine, was re-elected secretary-treasurer and Dr. J. M. Rowland, dean of the University of Maryland Medical School, was made vice-president. Dr. Charles P. Emerson, dean of the Indiana University School of Medicine at Indianapolis, was made general chairman in charge of arrangements for the convention.

The Indiana Society for Mental Hygiene will hold its thirteenth annual meeting and conference in Indianapolis, December 10th, with headquarters at the Claypool Hotel. Among the speakers who have been secured are E. R. Johnstone, director, training school for feeble-minded, Vineland, N. J., and Dr. Herman Adler, state criminologist, Illinois Department of Public Welfare. The Society for Mental Hygiene solicits the co-operation of all groups and individuals interested in the promotion of mental health. A program of the annual conference can be had by addressing the

secretary, J. A. Brown, 416 State House, Indianapolis.

THE Public Health Service recently has authorized the probational release of eight lepers from the National Leprosarium at Carville, Louisiana, as no longer a menace to the public health. These eight lepers have been under treatment at the National Leper Home for varying lengths of time, ranging from two to seven years. The National Leprosarium at Carville has been operated by the U. S. Public Health Service for a little more than seven years, during which time thirty-seven lepers have been released or paroled as being no longer dangerous to public health. Only one of these lepers has suffered a relapse and has had to resume treatment. More than three hundred lepers are now under treatment at this institution.

GROWING activities of commercial firms in chemo-therapeutic research, in collaboration with universities and clinics has led to much comment on the part of the medical profession. During the past ten years the Abbott Laboratories of North Chicago, Illinois, has taken a place in the front rank of pharmaceutical manufacturers through its research work. It is understood that this firm, together with its subsidiary, the Dermatological Research Laboratories of Philadelphia, expended more than $100,000 in research work in the year 1927. A new scholarship for chemo-therapeutic research at Northwestern Medical School of Chicago has just been announced by Dr. Alfred S. Burdick, president of the Abbott Laboratories.

REAR ADMIRAL CARY T. GRAYSON has accepted the presidency of the Gorgas Memorial Institute which was offered to him at the annual meeting of the board of directors held in Boston on October 10th, and has announced that he will maintain the field operations of the organization and expand its publicity features as far as funds will permit. Admiral Grayson's application for retirement from the active list of the navy, effective November 1, was acted upon favorably by President Coolidge, so that Admiral Grayson will be able to devote his entire time to the Memorial activities. President Coolidge is the honorary president of the Gorgas Memorial. The surgeon generals of the U. S. Public Health Service, Army and Navy, are on the board of directors.

IN addition to the articles already enumerated, the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:
- Ampoules Metaphen Solution 1:1,000, 10 cc.

Eli Lilly & Co.:
- Erysipelas Streptococcus Antitoxin (Lederle) Refined and Concentrated.
- Tetanus Antitoxin, 20,000 units.

H. K. Mulford Co.:
- Diphtheria Toxin for the Schick Test, two 10 cc. vial packages.

Parke, Davis & Co.:
- Tetanus Antitoxin Globulin, 20,000 units.

E. R. Squibb & Sons:
- Diphtheria Toxin Antitoxin Mixture (Sheep)-Squibb.
- Diphtheria Toxoid-Squibb.
- Parathyroid Hormone-Squibb.

United States Standard Products Co.:
- Diphtheria Toxin-Antitoxin Mixture 0.1 L + (Non-Sensitizing).

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION

BUREAU OF PUBLICITY

September 17, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. A. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held September 10 read, corrected and approved.

Newspaper release briefing the presidential address to be made at the annual meeting at Gary presented to the committee and approved for publication in the afternoon papers of September 27 and morning papers thereafter.

Handbook No. 3, entitled "The Control of Lay Health Agencies," on the relations between the Cattaraugus County Medical Society and the Milbank Demonstration received.

Editorial appearing in the August 25 issue of the *Saturday Evening Post,* entitled "Nine Years Going Begging," was reviewed and praise of the *Saturday Evening Post's* attitude in regard to scientific medicine was expressed by the Bureau. A few of the outstanding parts of the article follow:

"The richest and the least-worked mine of health, happiness and potential wealth lies in the field of preventive medicine. The achievements of modern medicine during the past thirty or forty years may be fairly called stupendous. * * *

"The result of these and of other advances is that during the past generation nine years have been added to the span of human life. This long series of medical triumphs, glorious as it is, loses much of its glamor when we reflect that if we gave our doctors full swing they could add another nine years almost immediately. * * *

"Preventive medicine should begin in the home. It should start with the habit of having periodical medical examinations, two or three times a year for young, old and middle-aged, annually for those in their twenties and thirties. * * * "

The secretary was instructed to see that this article is brought to the attention of the editor of THE JOURNAL.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole October 8, 1928.

WILLIAM N. WISHARD, M.D.,
Chairman.

THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

October 8, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. A.

MacDonald, M.D., by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held September 17 read and approved.

The release, "Hoosierland's Health Harvest," reviewed for publication October 13.

The following radio talks have been broadcast over Station WFBM at 6:30 each Saturday night:

Sept. 1—Preparation of Children for School.
Sept. 8—Competitive Athletics.
Sept. 15—Shock.
Sept. 22—Shock Troops Against Disease.
Sept. 29—Airplane Stunting for Deafness.
Oct. 6—Hoosierland's Health Harvest.

The Bureau reviewed the clippings of the articles on the convention which appeared in the papers, and expressed satisfaction with the amount of space given to the meeting, both by the Gary and Lake County papers and the press of the state in general.

Suggestion was made that radio releases be sent to each Indiana station with a letter stating the fact that these releases are purely educational and that the station would be welcome to use this material if it so desired. The secretary was instructed to get a list of radio stations in Indiana.

The Bureau expressed its appreciation for the kind words from the House of Delegates in regard to its work during the annual session at Gary, September 26, 27 and 28.

The following bills were approved for payment:

A. B. Dick Company	$ 4.00
Central Press Clipping Service	7.92
	$11.92

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole October 15, 1928.

WILLIAM N. WISHARD, M.D.,
Chairman.
THOMAS A. HENDRICKS,
Secretary.

BUREAU OF PUBLICITY

October 15, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; M. N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held October 8th read and approved.

The release on "Ringworm a 'New' Disease" was considered and the secretary was instructed to consult a dermatologist about this article and refer it back to the committee.

Bureau reviewed clipping from the *Indianapolis Star* telling of the arrest of "Dr." Alfred Ernest George Hall, who was to deliver a lecture at Cadle Tabernacle, billed as "a psychologist and dean of the American Academy of Psychological Research." The arrest was made as a result of charges preferred by the Indianapolis Better Business Bureau. Hall is desired in Chicago for alleged practice of medicine without a license. The secretary was instructed to send clipping to the American Medical Association and also to the editor of THE JOURNAL of the Indiana State Medical Association.

The weekly radio releases over Station WFBM are to be discontinued until after the election. The discontinuance of these releases is due to the fact that the usual hour given to these talks on Saturday night has been taken up with political talks for the rest of the month and for the first week in November.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole October 29, 1928.

WM. N. WISHARD, M.D.,
Chairman.
THOS. A. HENDRICKS,
Secretary.

WOMAN'S AUXILIARY

The Woman's Auxiliary to the Indianapolis Medical Society was entertained Friday, October 19th, at "Bonnie Brae" the country home of the president, Mrs. David Ross. A program of readings was given by Mrs. Charles McNaull. During the business meeting it was decided to petition the Park Board for permission to plant trees in the area surrounding the City Hospital, in honor of pioneer physicians, and to hold a meeting early in November in honor of John Kissinger, who lives near Huntington, and who offered himself for experimentation in the search for a cure of yellow fever. The ideals of the Woman's Auxiliary combine pleasure and service, and these plans of the Indianapolis members are along the line suggested by national officers.

Mrs. A. C. Clauser, Delphi, state secretary, and president of the Auxiliary to the Carroll County Medical Society, is sending state and national dues to the treasurer, Mrs. O. T. Scamahorn, Pittsboro. These are the first dues to be paid and will be appreciated by officers who are financing the State Auxiliary. According to the constitution adopted at the Gary meeting: "Each county auxiliary shall pay annual dues to the state auxiliary at the rate of fifty cents per capita, this to include the dues of twenty-five cents per capita to the Woman's Auxiliary to the American Medical Association. Dues are payable after October first. Auxiliaries are delinquent after March thirty-first."

Plans are going forward for the organization of a Woman's Auxiliary to the Seventh District Medical Society, at Martinsville, October thirtieth. Mrs. Edward M. Pitkin, of Martinsville, writes that she called together local physicians' wives and that they are in favor of organizing an auxiliary to the Morgan County Medical Society at the same time. The program of October thirtieth will include a card party and the organization work in the afternoon at the Martinsville Sanitarium, where the banquet and musicale will be held in the evening. Mrs. Pitkin concluded her letter. "We are looking forward to a delightful day, a better acquaintance, and a successful organization of the auxiliary here." Gradually the membership of the Woman's Auxiliary to the A. M. A. grows; it now enrolls ten thousand members in thirty-one states, with eight other states in the process of organization. Again let me say, our success depends upon the co-operation of our physician-husbands.

The Executive Board meeting of the Woman's Auxiliary to the A. M. A. will be held at the Stevens Hotel, Chicago, November 17th, with Mrs. Allen H. Bunce, Atlanta, Georgia, president, presiding.

The policy of Mrs. Bunce's administration is the organization of the "internal" body of the auxiliary, and the establishing of a budgeting system of expenditures; also a method of procedure at annual meetings that will give time for auxiliary business and for social affairs.

The National Bulletin is being sent out now; any one not receiving a copy kindly notify Mrs. M. T. Edgerton, 788 Penn Avenue, Atlanta, Georgia.

Respectfully submitted,
MRS. F. W. CREGOR,
State President.

VANDERBURGH COUNTY MEDICAL SOCIETY

Evansville, Indiana,
October 23, 1928.

The regular monthly meeting of the Vanderburgh County Medical Society was held at the Deaconess Hospital, Evansville, Tuesday, October 9, at 8:00 p. m.

A number of interesting cases were presented by the staff members.

Dr. J. H. Willis presented the history of a patient, aged fourteen, who had a large abdominal tumor. At operation a large ovarian cyst was removed without rupturing. Microscopical examination proved the cyst to be an adenocarcinoma. The patient, six months after the operation, was doing exceptionally well and showed no evidences of a recurrence of the tumor mass.

Dr. A. E. Newman presented a patient who had a lesion on the penis which was not a typical leuetic lesion. A number of dark field illuminations were negative for the spirochaete pallidum. The patient was discharged. Three months later the patient returned with a marked secondary syphilitic eruption. At this time the patient informed him that a mercurochrome ointment had been applied to the penile lesion locally. Dr. Newman emphasized the danger in the application of antiseptics to a penile lesion until a definite diagnosis had been made.

Doctors A. R. Rietz and Armstrong presented some interesting lantern slides of fracture of the superior and inferior maxillae. They discussed the treatment of fractures of this kind.

Preparations were gotten under way for the 1929 meeting of the Indiana State Medical Association.

Dr. W. T. Bennie was received into the society as a new member.

KEITH D. MEYER, M.D.,
Secretary.

VIGO COUNTY WOMAN'S AUXILIARY

Terre Haute, October 9, 1928.

The Woman's Auxiliary to the Vigo County Medical Society held its first meeting of the fall on October 1, 1928, at 2:30 p. m. at the Y. W. C. A.

Reports of the A. M. A. meeting at Minneapolis and the state meeting at Gary were given, and Mrs. McReynolds's address to the House of Delegates (at the A. M. A. meeting) was read. These were all most interesting. After the business meeting tea was served.

Respectfully submitted,
MRS. O. O. ALEXANDER,
President.

ELKHART COUNTY MEDICAL SOCIETY

October 10, 1928.

On Thursday evening, October 4th, the Elkhart County Medical Society met for its regular monthly meeting at Hotel Elkhart, the president, Dr. D. D. Todd, presiding. After dinner the following program was given:

"Trusts"—Mr. A. B. Hussander, Chicago, Assistant Secretary, Illinois Merchants Trust Company.

"The Best Investment"—Rev. T. E. George, Goshen.

The November meeting will be held in Goshen November 8th. Dr. Andrew C. Ivy of the Northwestern University Medical School will give an address on "Etiology of Gastric Ulcer." Dr. Robert Moore, of Indianapolis, is expected to be on the program.

S. T. MILLER,
Secretary Elkhart County
Medical Association.

MADISON COUNTY MEDICAL SOCIETY

Anderson, Ind., October, 1928.

The first fall meeting of the Madison County Medical Society was held at the Grand Hotel on Tuesday evening, October 16th, at 6:30 p. m. This meeting was a joint meeting of the Medical Society and the Dental Association. It considered one of the most important of our medical problems, that of focal infections, particularly emphasizing those of the nose, throat and teeth. Dr. J. K. Leasure, of Indianapolis, was our guest and read a paper on "The Relations of Nasal Accessory Sinus and Dental Infections," which was discussed by Dr. A. D. Erehart. Dr. C. W. Jones discussed the dental conditions and showed a number of plates illustrating the x-ray findings. The prevailing opinion is that there has been altogether too much radicalism used in doing away with both teeth and tonsils. On the other hand, so-called conservatism has been the cause of more serious after results than has the removal of either teeth or tonsils. That there is a middle ground of safety both for the medical adviser and his patient one is certain to accept sooner or later, and it is this just viewpoint that was presented at this meeting.

The recent State Medical Society meeting was unusually well attended and those who heard even half of the papers that were presented were well repaid for their time and expense.

M. A. AUSTIN, M.D.,
Secretary.

TIPPECANOE COUNTY MEDICAL SOCIETY

Lafayette, Indiana.
September 13, 1928.

The Tippecanoe County Medical Society met in regular session at the Lafayette Country Club with Vice-president Bayley presiding. Dinner was served at 6:15 p. m., thirty-nine being at the table. The minutes of the June meeting were read and approved.

This being a meeting of the Tippecanoe and Montgomery societies the program was presented by the members of the Montgomery Society. The subject was "Hemorrhage, Its Cause and Management." The first speaker was Dr. B. N. Lingeman, who spoke from the ear, nose and throat standpoint; the second speaker was Dr. Beason, speaking from the dentist's standpoint; the third speaker was Dr. G. A. Collett who spoke from the standpoint of the general surgeon; the fourth speaker was Dr. R. A. Millis who spoke from the standpoint of the obstetrician. Each speaker related very interesting experiences which he had had in dealing with hemorrhage in progress.

A very friendly and interesting discussion was carried on by members of the Tippecanoe County Society, the first discussant being Dr. J. S. Morrison, speaking as an obstetrician; second was Dr. S. Pearlman speaking from the standpoint of the eye, ear, nose and throat; third, Drs. Washburn and Crockett, speaking from the standpoint of the urologist. Dr. R. D. Bayley discussed from the standpoint of the internist, Dr. F. T. Rombuerger related some interesting experiences in his work as an anaesthetist in assisting in tonsil work. He emphasizes that the cause may come from too strong a suction or from too much pressure in the fossa. Dr. R. G. Ikens gave the indications and technique of blood transfusion. The question was asked, "Of what value is fibrogen in prevention of hemorrhage?" Dr. Bayley related his experience in the use of fibrogen stating there are a few cases in which favorable results have followed its use, however, it cannot be relied on as a routine measure.

October 11, 1928.

The Tippecanoe County Medical Society met in regular session, October 11, 1928, at Lafayette. Dr. Clifford G. Grulee, of Chicago, held a very valuable clinic from 2:30 to 5:15 in the afternoon and some interesting cases were presented. In the evening Dr. Grulee presented a paper on "Anemia in Infants and Children", in which he showed how premature babies are more anemic, emphasizing the fact that while some babies are anemic from birth and do not respond to treatment, others apparently as bad get well without treatment. Particular emphasis was laid upon Von Jaasch's anemia, iron as used in the treatment of these cases, the various forms recommended and the amount of dependence to be placed upon this treatment. Blood transfusion is recommended always typing the blood and making repeated transfusions as needed.

J. C. BURKLE, M.D., Secretary.

CORRESPONDENCE

THE NEW CHRISTIAN SCIENCE BELIEF AND PRACTICE

The Christian Science Watchman
20 Jackson Place N. W., Washington, D. C.

Office of the Editor,
October 17, 1928.

Editor THE JOURNAL:

The tragedies that have been permitted in the name of Christian Science by its overzealous devotees have largely justified the widespread prejudice against it. The Christian Science Parent Church, the independent minority movement in Christian Science, is endeavoring to bring a new spirit of sanity and common sense into the practice of mental healing. It recognizes the unselfish, humanitarian labors of the medical profession in alleviating human suffering. It likewise recognizes the vital function of spiritual forces in relation to health. It is convinced that there exists a basis of cooperation on which medicine and religion may thrive together for the advancement of world health.

Since Mrs. Eddy's death, Christian Science practice has very largely become a commercialized faith-cure. The record of disease and death among Christian Scientists during the last few years is appalling. Because of a superstition that the use of a drug is an evil and the employment of medical aid tantamount to a confession that Christian Science has failed, the majority of the adherents of that faith turn to medical assistance only as a last resort, usually secretly and with the depressing conviction that they are committing a positive sin. Such an attitude tends to nullify the work of the physician and deplete the patient's mental capacity for recuperation. Frequently the doctor is called only when death is considered imminent, and to prevent, if possible, the embarrassment of an inquest.

These conditions have arisen from a misconception of Christian Science in its larger application. In order to prove to an incredulous world that the body can be healed by mind, drugs were discarded during the early stages of the movement. Nevertheless, it is a recognized fact in Christian Science that a drug may be the medium through which the common faith and hope of the majority of mankind expresses itself. In the personal experience of Mrs. Eddy there came a time when neither her own nor her followers' unaided faith was sufficient to relieve her of serious suffering. Understanding the power of the faith of the majority of mankind in medical science she decided to utilize it, and gratefully availed herself of the services of reputable physicians on various occasions.

In so doing, she was consistent with her own teaching on the relation of a minority's faith in mind-power to a majority's faith in material means. She was far in advance of her followers' practical application of Mind-Science. Had her example been intelligently followed by her students, Christian Science practice would today hold a higher place in the general estimation of the world.

The Christian Science Parent Church was organized a few years ago under the leadership of Mrs. Annie C. Bill. It has developed branches throughout Great Britain, America, Australia, and elsewhere. Its members have been recruited almost entirely from those who have resigned from the original Christian Science organization after they became convinced that the trend of thought within that body precluded further advancement of mind-science.

This organization maintains that the work of the Christian Scientist is limited to the teaching of spiritual truth, and to removing fear and other unhealthful moral conditions. Its members are forbidden by their church by-laws to meddle in any way with medical or surgical practice, but must leave such work to those who are qualified and legally authorized for that responsibility. Neither shall a practitioner of this church render his services unless both patient and attending physician request his aid.

Spiritual healing has a definite place in therapeutic practice. Therefore, in order that it may be utilized under such conditions as will keep it within its proper field and insure the maximum results, we bespeak the intelligent cooperation of the medical fraternity.

Yours very truly,
A. M. VICKERY,
Editor.

CONCERNING MARKETING OF PHYSIO-THERAPY APPARATUS

Office of the
Secretary and Treasurer
Frank S. Betz Company
Hammond, Ind.
October 25th, 1928.

Editor THE JOURNAL:

We have read with interest two of your editorials, one concerning increasing incomes through the use of ultra-violet ray apparatus and the other regarding extravagant advertising of physio-therapy apparatus.

Perhaps you are not interested in knowing whether or not we approve of these articles. Anyway, we are very much in favor of them and if you ever discover a piece of advertising from this firm which you feel should be criticized under either head, we certainly would be glad to hear from you.

It is our intention to make apparatus, but not to tell anyone where to use it. Further it is the policy of this house to sell this apparatus to licensed physicians only. We do not sell physio-therapy apparatus to the laity except under one condition. The person buying such apparatus must have a prescription from his physician. We have turned down many orders for carbon arc lamps, etc., on this basis and expect to continue to do so.

If you can suggest any form of advertising which will help to kill off the effect of extravagant claims for physio-therapy apparatus, we will be glad to receive your suggestions.

Sincerely yours,
FRANK S. BETZ COMPANY,
By R. E. AMOSS,
Secretary and Treasurer.

SOCIALISTIC MEDICINE BY THE STATE BOARD OF HEALTH

Fort Wayne, Indiana,
October 25, 1928.

Editor THE JOURNAL:

At the Gary session of the Indiana State Medical Association a resolution was introduced concerning the policies of the laboratory of the Indiana State Board of Health. The resolution and discussion of the same was published in full in the October number of THE JOURNAL. As a clinical pathologist intensely interested in this subject I herewith present my views for the earnest consideration of the medical profession.

The specialty of clinical pathology is suffering from conditions not found *at present* in other fields of medicine, especially from an economic standpoint. Two factors are instrumental:

First, the fact that too many physicians are satisfied with the incompetent work of technicians.

Second, *the socialistic activities of the laboratory of the State Board of Health.*

It is a fact that on account of these conditions many good clinical pathologists are leaving this field of medicine; and as there is at present no incentive from an economic standpoint for young men to make clinical pathology their life work, there is a great dearth of good pathologists; which condition will grow worse, unless these evils are corrected. If the state laboratory continues broadening its scope of work, the time is not far distant when there will be no private laboratories. This would

represent a distinct and serious loss to any community, and to the medical profession. Just now there are only eight hundred clinical pathologists, and one hundred sixty approved laboratories in the United States.

Practically all of the great discoveries and advances in pathology, physiology, bacteriology, serology, etc., that have made our present day scientific medicine possible, have been brought about by pathologists in their laboratories. Is the medical profession then, from the standpoint of saving a few dollars, going to drive these men out of existence by employing incompetent technicians in their offices, or by sending their laboratory work to the state laboratory? We as clinical pathologists feel that all these advances in medicine have justly earned and entitled us to "our place in the sun", to a right to make a decent living. The American Medical Association and the College of Surgeons have recognized this condition and have started a movement to improve the status of the clinical pathologist, first by standardizing hospitals whose laboratory is supervised by a competent clinical pathologist, and second, by *approving* the private laboratory of the clinical pathologist. Even so, their work will be in vain unless something is done to combat the open competition of the state laboratory for, unfortunately, due to the aims of heads of state laboratories to make big statistical showings, to bring more influence, power and prestige to their offices and consequently larger salaries and bigger appropriations, they are extending their activities far beyond the purposes for which they are created. Lo! even if possible, to the extent of a socialistic state of medicine in which they would be on the throne as rulers and dictators.

As a result of these activities, the major part of the work done in state laboratories is for the private practice of physicians. No distinctions are made as to whether the examination has any bearing on the public health, and no attention is paid as to whether the individual receiving the service is a proper subject for free medical service. It is right and proper that state laboratories do the laboratory work for state institutions and county health offices and for indigents, although private laboratories are perfectly willing to do the charity laboratory work of their patrons, but otherwise, according to law, the state laboratory should confine itself to problems of sanitation, water supplies, sewage and control of epidemics. The free service they offer and advertise to physicians presents a constant temptation and opportunity for unscrupulous physicians, grafting quacks and cultists, to have their private laboratory work done at the state laboratory at the taxpayers' expense, while they charge the patient for the work and pocket the money. Of course the state laboratory officials claim that they do Wassermanns to control a communicable disease. Probably ninety per cent of the Wassermanns they do are routine or check Wassermanns on private patients of physicians, and these examinations have not the remotest bearing on the enforcement of public health measures nor does the state laboratory take any measures on the basis of these examinations to control the disease.

Physicians following the practice of sending laboratory specimens from their well-to-do patients to the state laboratory, are blindly sealing their own doom by facilitating an entering wedge of state medicine, which eventually will include their specialties and lead to the deplorable state of affairs as exists in England and the Continent where the profession has descended to the ranks of the proletariat on a wage lower than that of a skilled artisan.

Why should the state, county or city furnish free laboratory or medical service to people able to pay? Poor people unable to pay are "put on the county", and most people feel this is a disgrace. But what difference is there between the county or state giving some poor individual in need medical attention, a load of coal or provisions, and giving some well-to-do citizen a free Wassermann or tissue examination? The difference is that the first is real charity, while the second is pauperizing individuals who would consider it an insult if the state offered them a ton of coal.

That the movement toward state medicine, having as its foundation free laboratory service, is growing rapidly there is no doubt. One has only to read the request of the secretary of the State Board of Health to the legislature for this year's appropriation ($310,500) which is almost double that of the previous year ($180,500) as given in the public press, and read between the lines. The following items stand out:

Maternity and child welfare	$70,000
Health education	10,000
Public nursing service	10,000

Of course these socialistic activities on the face of them sound good, but experience has shown that in many of these matters it were much better for the welfare of the people and the medical profession if they were left to be worked out by the physicians in daily contact with the families under supervision. The danger is that this free service will continue to expand until it includes treatments and operations on rich and poor alike. The medical men should be aroused from their lethargy and, instead of contributing their services to the free clinics, which I understand, in so far as the babies are concerned, is more of a beauty contest among the well-to-do than a help to the poor, should unite in an effort to force the state laboratory to give up its invasion into the realms of private practice. This can be done by fighting this appropriation in the legislature.

The secretary of the State Board of Health professes that no practical solution of the laboratory problem can be found. I want to state that several methods have been advocated which if followed up *with sincerity and good faith on his part,* would go far towards confining the work of the state laboratory to its legitimate functions. For instance, on their Wassermann card is the question, "Is the patient indigent?" The state laboratory should refuse to do all Wassermanns not marked in the affirmative. In one state both the doctor and the patient sign a statement that the patient is unable to pay.

In the resolution previously mentioned, still another solution is offered. The secretary of the State Board of Health claims that he tried this plan and it got him into difficulties. Even so it would be expected that the unscrupulous doctor might howl. So would a hijacker if caught at his own game.

Respectfully submitted,
B. W. RHAMY, M.D.

DEDUCTIONS FROM INCOME TAXES OF PHYSICIANS

Indianapolis, Ind.
October 25, 1928.

Editor THE JOURNAL:

Unofficial word has been received that within the last few days the Board of Tax Appeals at Washington has granted physicians the right to deduct traveling expenses while attending medical meetings in computing their income taxes. This right was gained through the Board of Tax Appeals at Washington which overruled the decisions of the Commissioner of Internal Revenue upon which this unjust discrimination against physicians has been based for the last seven or eight years.

Physicians may now make claim to the Commissioner of Internal Revenue for refund because of the failure of the Commissioner to allow them deductions for attending meetings of medical societies during each of the last four years. This application for refund should be made on Form 843 of the Internal Revenue Service which may be obtained from the local Revenue Officers in the following cities or from George Foote, Collector of Internal Revenue at Indianapolis: Gary, Hammond, South Bend, Michigan City, Fort Wayne, Terre Haute, Evansville, New Albany, Vincennes, Columbus, Shelbyville, Newcastle, Muncie, Elwood.

As you may recall, Dr. William C. Woodward, head of the Bureau of Legal Medicine and Legislation of the American Medical Association, has made a vigorous attempt for a number of years to correct this unjust discrimination against the medical profession. On numerous occasions in the past the Commissioner of Internal Revenue has refused to allow physicians to deduct these traveling expenses and now the battle which will save the physicians of Indiana and of the country many hundreds of dollars has been won.

TOM HENDRICKS,
Executive Secretary.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books received since October 1, 1928:

UROLOGY. By Edward L. Keyes, M.D., Ph.D., Professor of Urology, Cornell University Medical College. 763 pages, with 184 illustrations and twenty plates, two in color. Cloth. Price, $10.00. D. Appleton & Company, New York and London, 1928.

TEXTBOOK OF PHARMACOLOGY AND THERAPEUTICS. By Hugh A. McGuigan, M.D., Professor of Pharmacology and Therapeutics, University of Illinois School of Medicine, Chicago. 660 pages, illustrated. Cloth. Price $6.00. W. B. Saunders Company, Philadelphia and London, 1928.

TEXTBOOK OF UROLOGY. For students and practitioners. By Daniel N. Eisendrath, M.D., attending urologist Michael Reese and Chicago Memorial Hospitals; assistant professor of surgery (genito-urinary) Rush Medical College; and Harry C. Rolnick, M.D., associate urologist Mt. Sinai Hospital, adjunct urologist Michael Reese Hospital, etc. 939 pages, with 700 black and white illustrations and eleven colored illustrations. Cloth. Price $9.00. J. B. Lippincott Company, Philadelphia and London, 1928.

SURGICAL CLINICS OF NORTH AMERICA. (New York Number) Volume 8, number 5. October, 1928. 293 pages with 141 illustrations. Per clinic year, February, 1928, to December, 1928: paper, $12.00; cloth, $16.00. W. B. Saunders & Company, Philadelphia and London, 1928.

PROBLEMS IN SURGERY. University of Washington Graduate Medical Lectures for 1927. By George W. Crile, M.D., edited by Amy F. Rowland. 171 pages, illustrated. Cloth. Price $4.00. W. B. Saunders & Company, Philadelphia and London, 1928.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

EPHEDRINE HYDROCHLORIDE-SQUIBB. — A brand of ephedrine hydrochloride-N. N. R. (New and Nonofficial Remedies, 1928, p. 175). E. R. Squibb & Sons, New York.

SYRUP EPHEDRINE HYDROCHLORIDE-SWAN-MYERS.—A syrup containing ephedrine hydrochloride-Swan-Myers (New and Nonofficial Remedies, 1928, p. 176) 0.2195 Gm., in 100 cc. (1/8 grain per fluidrachm) and alcohol 12 percent. Swan-Myers Co., Indianapolis.

POTASSIUM BISMUTH TARTRATE WITH BUTYN-D. R. L., 20 cc.—Each cc. contains potassium bismuth tartrate-D. R. L. (New and Nonofficial Remedies, 1928, p. 110) 0.1 Gm.; butyn, 0.6 percent; and metaphen, 0.01 percent suspended in expressed oil of almonds. Abbott Laboratories, North Chicago.

SCARLET FEVER STREPTOCOCCUS TOXIN FOR SKIN TEST-P. D. & Co.—It is prepared by the method of Drs. Dick by license of the Scarlet Fever Committee, Inc. (New and Nonofficial Remedies, 1928, p. 392). It is marketed in single 1 cc. vial packages, containing sufficient toxin for ten tests. Parke, Davis & Co., Detroit. —(*Jour. A. M. A.*, September 1, 1928, p. 645).

AMPOULES METAPHEN SOLUTION 1:1,000, 10 CC.—1 part metaphen (New and Nonofficial Remedies, 1928, p. 274) dissolved in 1,000 parts of water by means of sodium hydroxide (four molecules of NaOH for every molecule of metaphen). Abbott Laboratories, North Chicago.

ERYSIPELAS STREPTOCOCCUS ANTITOXIN (LEDERLE) REFINED AND CONCENTRATED.—An erysipelas streptococcus antitoxin (New and Nonofficial Remedies, 1928, p. 353) prepared by immunizing horses by subcutaneous injections of the toxic filtrate obtained from broth cultures of the erysipelas streptococcus, or by intravenous injection of cultures of the erysipelas streptococcus obtained from typical cases of erysipelas. It is marketed in packages of one syringe containing one basic dose. Lederle Antitoxin Laboratories, New York.

DIPHTHERIA TOXOID-SQUIBB.—A diphtheria toxoid (*Jour. A. M. A.*, August 4, 1928, p. 321) prepared from diphtheria toxin by treatment with formaldehyde as prescribed by the U. S. Public Health Service to secure detoxification. It is marketed in packages of one immunization treatment containing one 1 cc. ampule of diluted diphtheria toxin for the reaction test and two 1 cc. ampules of diphtheria toxoid for treatment. E. R. Squibb & Sons, New York.—(*Jour. A. M. A.*, September 22, 1928, p. 883).

PROPAGANDA FOR REFORM

TUBERCULIN. — Investigation at the Otho S. A. Sprague Memorial Institute at the University of Chicago makes it evident that the water-soluble protein in tuberculin is similar in many of its properties to ovalbumin. These studies have resulted in the isolation of the active principle of tuberculin in crystalline form.—(*Jour. A. M. A.*, September 1, 1928, p. 648).

CAFFEINE IN BEVERAGES.—The report of the U. S. Department of Agriculture indicates that, despite continued growth in population, nearly six and one-half million pounds less tea was imported during the fiscal year ending June 30, 1928, than during the previous year. This represents a decrease of seven percent. In contrast with this is the governmental announcement that caffeine-containing drinks other than tea and coffee are now being used extensively with meals at lunch counters, cafeterias and similar eating places. Those who have hopefully anticipated a decrease in the "caffeinization" of the nation will be further disconcerted by the information that of several million pounds of tea waste, tea siftings and tea sweepings which have been imported "for manufacturing purposes" practically all are reported to be converted into caffeine, a large portion of which is used in the preparation of caffeinated soft drinks.—(*Jour. A. M. A.*, September 1, 1928, p. 649).

ALZAMON IRA LUCAS MEETS HIS WATERLOO.—Alzamon Ira Lucas, who has a long record of quackish activity ranging from "mind reader," "sex" lecturer to promoter of an "American Super-Race Foundation" has been found guilty on the complaint of a woman who charged that he defrauded her of $250 by falsely representing that he could cure her of lung trouble and "awaken life within her." According to newspaper reports Lucas is a negro; he denies this, but admits a mixture of Indian, Dutch, French, Hindu, and Spanish blood. According to his advertising booklet, the "super-race" concern offered to teach members "how to prevent the birth of subnormal and degenerate children," and at the same time, "how to predetermine the sex and vocation of children." The health authorities and Better Business Bureau of Rochester, New York, were largely instrumental in securing a two to four years' sentence for this blatant quack.—(*Jour. A. M. A.*, September 1, 1928, p. 661).

ARSAMINE.—According to the advertising for "Arsamine" of S. Lewis Summers, this preparation is "diarylarsonate," but no definite statement of composition is made.

It is believed that a constantly increasing number of physicians are refraining from the use of proprietary medicinal articles which have not been reported on favorably by the Council on Pharmacy and Chemistry. This is in accordance with the report of the board of trustees of the American Medical Association to the House of Delegates in 1927 urging support of the work of the Council by confirming the use of proprietary drugs to those found acceptable for inclusion in New and Nonofficial Remedies. The claims that have been made by Dr. S. Lewis Summers for Befsal which were the subject of a report, "Befsal Another Alleged Synthetic" (*Jour. A. M. A.*, February 21, 1925, p. 611), constitute ample justification for questioning the claims made for Arsamine.—(*Jour. A. M. A.*, September 1, 1928, p. 664).

AEROSAN TABLETS NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that the Aerosan Company of America, New York, offers Aerosan Tablets (which the firm proposes to market under a new name, "Benzomenteriodol") and a lamp for their vaporization as a "new dry inhalation treatment, by Dr. P. Rosenberg of Berlin." A circular letter contains the statement that the tablets contain: menthol, terpene, pinene, benzoic acid ester, tetraiodopyrrol, chinoline bisulphate and paraform. The distributers informed the Council that the respective quantities of each constituent of the tablets was not known to them and no information in regard to the identity of the benzoic acid ester was offered. (Subsequently, they stated the ester to be benzylbenzoate.) Without considering for the present other conflicts with its rules, the Council declared "Aerosan"—to be marketed as Benzomenteriodol—unacceptable for New and Nonofficial Remedies because it is an unscientific mixture of indefinite composition which is marketed under unwarranted therapeutic claims.—(*Jour. A. M. A.*, September 8, 1928, p. 727).

THE INVESTIGATION OF GERMICIDES.—J. S. Simmons has studied the bactericidal action of mercurochrome-220 soluble and iodine solutions in skin disinfection and F. E. Rodriguez has studied the action of mercurochrome and iodine as disinfectants of the mucous membrane of the mouth. After taking swabs of the treated areas, they streaked the material directly, without previous dilution, on the surface of an agar plate. This procedure, it is agreed, will give inhibitory effects and may be an unfair test, because no two drugs have exactly the same inhibitory index. It has been found that iodine has a higher inhibitory effect than mercurochrome and it seems likely that the amount of iodine carried over to the plates might have been sufficient to inhibit growth of the bacteria without being bactericidal. G. F. Reddish and W. E. Drake studied the action of mercurochrome-220 soluble and U. S. P. tincture of iodine as to comparative germicidal efficiency. These investigators used scrapings from the skin surface in a way to dilute considerably any antiseptic that may be present. They made controls to prove that no drug inhibition took place in their tests. In other respects the work of Simmons and Rodriguez introduced errors which Reddish and Drake tried to avoid. However, whatever the final results of laboratory experiments may be, reliance should not be placed solely on such results; clinical observations must be considered.—(*Jour. A. M. A.*, September 8, 1928, p. 728).

THE VIT-O-NET AGAIN.—A report on the "Vit-O-Net Electro-Magnetic Blanket" and its method of exploitation was published in the *Jour. of the A. M. A.*, March 10, 1928. The Vit-O-Net is a large electric heating pad which sells for about $100. Now an attempt is being made to lead the public and medical profession to believe that the objectionable methods of eploitation have been abandoned. Further, the public is being told that every purchaser of a Vit-O-Net will be entitled to medical service for himself and all members of his family as long as he owns one of the blankets, and that this "Health Division is under the direction of a physician, an M.D., who also is a Master of Arts and a Fellow of the American Medical Association." The promoters feature the name of Dr. F. Bache Van Nuys as the health expert, and more recently, there has been issued an elaborate booklet in which practically all of the fantastic claims previously made for Vit-O-Net are repeated. The booklet contains a picture of F. Bache Van Nuys. On September 4, 1928, *The Journal* received a brief note from Dr. Van Nuys stating that he had resigned from the position of health director of the Vit-O-Net Corporation.—(*Jour. A. M. A.*, September 8, 1928, p. 743).

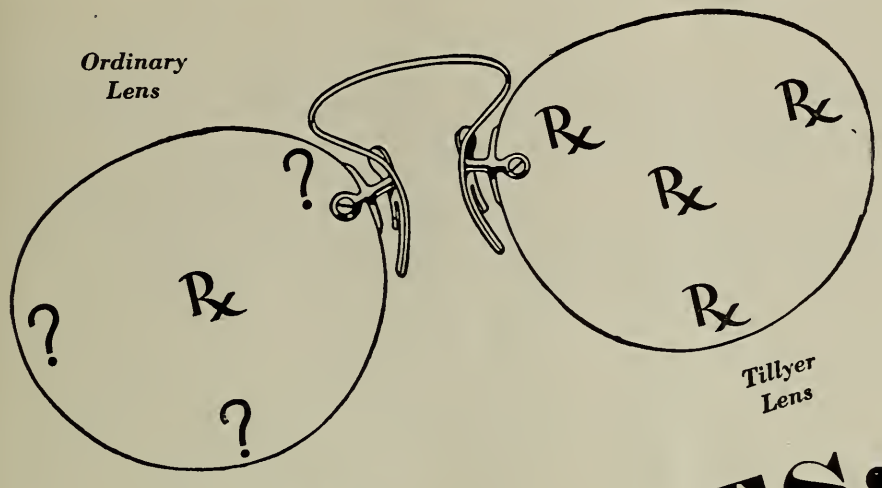
AVERTIN.—Avertin (also referred to as E. 107) apparently is tribrom-ethyl alcohol. A recent report by Hans Killian states that it is a useful sleep-producer and sedative, but that full narcosis cannot be produced with it without injuring the human organism. He holds that to introduce into the organism a molecule with properties so decidedly injurious to the vital centers in a single dose without knowledge of individual rapidity of absorption is dangerous. For more than thirty years rectal narcosis has been tried again and again, and has always been given up because, in opposition to inhalation-narcosis, it is not possible either to decide on the precise dose or to interrupt the narcosis when once produced.—(*Jour. A. M. A.*, September 8, 1928, p. 745).

THE PREVENTION AND MODIFICATION OF MEASLES.—Two years ago it was announced that protection was secured in eighty-five percent or more of susceptible persons exposed when convalescent measles serum was administered before the fifth day after exposure to measles and that in some cases the disease was modified when the serum was given as late as the seventh day. It has been attempted to produce a serum from animals by using the diplococcus isolated from patients with measles. Results have been reported from the use of such a serum developed in horses, but the production of immune goat serum seems even more promising. It is to be remembered, however, that the protection thus conferred is only transient. Active immunization with a toxin prepared from the causative organism of measles remains to be accomplished successfully. In Chicago a committee has concluded that as a general practice it is doubtful whether the immunization of all children exposed to measles is desirable.—(*Jour. A. M. A.*, September 15, 1928, p. 803).

DISTRIBUTION OF ARSENICALS IN THE BODY.—Arsenical dermatoses have long been known to follow the use of certain familiar arsenical drugs. By employment of microchemical methods it was demonstrated that, after administration of such products as Fowler's solution (solution of potassium arsenite) or Donovan's solution (solution of arsenous and mercuric iodide), arsenic becomes localized in the epidermis, subpapillary layer and other ectodermal tissues. On the other hand, keratoses and pigmentation appear to be in extreme rarity following the administration of arsphenamines. A new study has demonstrated a well-defined difference in localization of the arsenic following introduction of certain trivalent and pentavalent arsenicals. This may explain the pathologic processes that they produce and their therapeutic action. Arsenic in trivalent compounds has a special affinity for the vascular structures, while the pentavalent arsenicals seem to be directed toward the ectodermal structures.—(*Jour. A. M. A.*, September 15, 1928, p. 805).

DYNELL WATER.—In Palos Park, Illinois, a suburb of Chicago, there is a concern known as the Dynell Spring Water Company. For the past few years "Dynell Spring Water" has been advertised by methods that are more reminiscent of "Peruna" and "Lydia Pinkham" than of mineral waters. Dynell Water, if we are to believe the advertising—which is not advised—is the remedy *par excellence* for appendicitis, arthritis, asthma, Bright's disease, bladder trouble, and so on. According to an analysis, Dynell Water has, for its chief active ingredients, sodium sulphate (Glauber's salt) and magnesium sulphate (epsom salt). Included in the advertising are

(Continued on adv. p. xx)



to OCULISTS:

ALL THE WORDS we could write and all the pictures we could print would not take the place of two or three days' experience with Tillyer Lenses before *your own eyes.*

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AMERICAN OPTICAL COMPANY

TILLYER LENSES

Accurate to the very edge

TRUTH ABOUT MEDICINES

(Continued from page 508)

what are alleged to be testimonials of two physicians, who are members of the Chicago Medical Society, and a testimonial credited to William Hale Thompson, mayor of Chicago, and widely known in other ways.—(*Jour. A. M. A.*, September 15, 1928, p. 818).

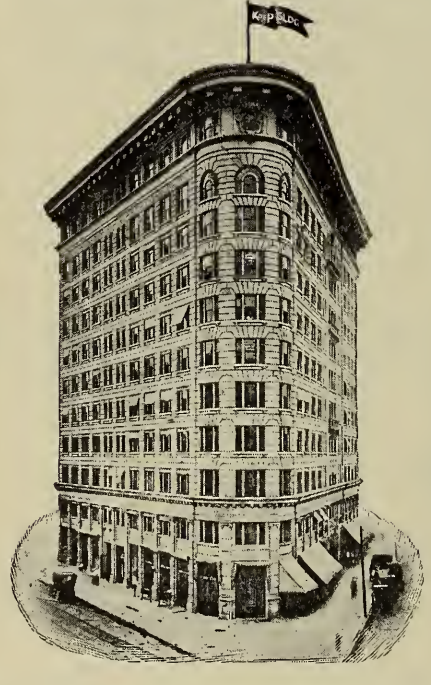
CAFFEINE-REDUCED COFFEES.—When the facts brought out by the A. M. A. Chemical Laboratory examination of caffeine-reduced coffees were brought to the attention of the manufacturers, the concerns involved immediately began checking up on their products. The Kaffee Hag and Sanka products changed hands about the time of the examination. From evidence that has been submitted since the A. M. A. analyses were made, it seems to be a fact that both Kaffee Hag and Sanka now contain caffeine in such minimal amounts as to be practically negligible. The third preparation, Blanke's Refined Health Coffee, still contains a relatively large amount of caffeine. Kaffee Hag and Sanka are now submitted by their manufacturers to daily checks of caffeine content, a procedure which did not prevail prior to the analyses by the A. M. A. Chemical Laboratory.—(*Jour. A. M. A.*, September 22, 1928, p. 886).

VITAMIN A DEFICIENCY AND INFECTION.—The susceptibility to infections of various kinds as affected by the adequacy or deficiency of diet with especial reference to the vitamins has attracted renewed interest. An increased susceptibility to tuberculosis has been shown in rachitic rats, a species normally possessing a marked immunity to such infection. The long-delayed effects of a mild deficiency of vitamin A "no greater than may readily occur within the range of ordinary normal or adequate nutrition" have been studied on rats. At the end of the experiment, autopsies were made and the incidence of infection was determined in all the rats. In the first group this was twenty-five percent; in the second, seventy-five percent. The only difference between the two groups was the dietary treatment of the mother and young up to the time of weaning, one series having plenty of vitamin A, while the other was somewhat limited in its supply. The similarity in the nutrition of the rat and of man permits these results to be translated into human age relationships and suggests that a difference in incidence of infection is to be expected among children of around ten and twelve years, resulting from differences in the way they were fed before they were three years old.—(*Jour. A. M. A.*, September 29, 1928, p. 962).

LEVENTIS' HUMANIZED SERUM.—Dr. Leventis assumes on the basis of vaguely cited "innumerable experiments" of eighteen years' duration that it is possible to render naturally immune animals susceptible to tuberculosis by injecting the serum of a susceptible animal. Without going into the unlikelihood of this exaggerated importance of the serum alone in the complex matter of immunity, any well-trained physician would wish to see carefully recorded experiments, many times repeated, and by others than the original investigator, and reported in the usual mediums of scientific exchange, before accepting this hypothesis. The United States Public Health Service has not authorized interstate sale of the Leventis serum.—(*Jour. A. M. A.*, September 29, 1928, p. 980).

BLADDER STONES AND MINERAL WATERS.—If treatment of bladder stones is interpreted as the employment of a method or methods to remove such concretions by other than operative means, it must be stated that we do not know of any mineral water or any other fluid that would be apt to dissolve vesical calculi. There is no evidence for supporting the claim that certain mineral waters have specific properties in preventing the formation of urinary concretions.—(*Jour. A. M. A.*, September 29, 1928, p. 981).

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THE JOURNAL
OF THE
INDIANA STATE MEDICAL ASSOCIATION

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ORIGINAL ARTICLES

BACTERIOPHAGE IN SUPPURATIVE CONDITIONS

(REPORT OF ONE HUNDRED AND FIFTY CASES)

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INDIANAPOLIS

Several months ago in THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION, March, 1928, we discussed in a preliminary way the use of bacteriophage filtrates in the treatment of certain suppurative conditions caused by the staphylococcus and by bacillus coli. Our experience was limited at that time to some twenty cases. Since then we have continued the work and beg to report a summary of the results obtained in over one hundred and fifty cases which have been under our observation. A large number of other cases in the care of colleagues has been reported to us but not made the subject of this report. We feel that so large a group assures us that we have not been observing a series of lucky accidents or coincidences. Furthermore, we wish at this time to report some of the limitations of this method of therapy that have come to light. With more experience we have learned several new tricks in the efficient application of the material, and have found that stock preparations of mixed strains of bacteriophage are apparently as good as the homologous strain except that they may not "hit" so often.

We do not intend to discuss in this place the problem as to how the agent acts, or whether we have here the action of the bacteriophage itself, an antivirus such as Besredka has described, the effect of an extremely available antigen in the form of the dissolved bacterial bodies, the forcing of the offending organism into an avirulent phase as a result of microbic dissociation, or the effect of the chemotactic action of peptone broth upon the tissues. These matters we have discussed elsewhere (*Journal of Laboratory and Clinical Medicine,* October, 1928). We have in mind merely to report the results in certain groups of cases.

BOILS AND CARBUNCLES. We have treated five cases of extreme generalized furunculosis in young children and babies. These patients were suffering from boils to the number of fifty in the mildest case to three hundred and fifty—by actual count—in the worst case. Their condition was serious—high temperature, emaciation, disturbance in nutrition. The bacteriophage was applied as a wet dressing to the lesions. In every case the child was markedly improved the next day, the temperature was down, the lesions were less painful, small boils promptly regressed and large ones rapidly came to a head, opened spontaneously, and new lesions ceased to appear.

Nine cases of "crops of boils" in adults were treated. In every case the patient got relief from pain at least to a considerable degree. Most of the cases got complete relief quite promptly. As a rule the boils ceased to appear, but in two cases they continued to develop in new sites, though less frequently. In fifteen cases in which the patient had from one to five large boils there was spectacular relief in twelve. In one failure the boil was very deep in a thick layer of fat. Local application could not reach the site of the trouble, and injection with the bacteriophage was not permitted. In another case the streptococcus was the causative agent and in still another the staphylococcus was not susceptible to the stock phage used as tested in the culture tube. The prompt relief of pain, and the very rapid fluidification of the necrotic core made the results quite surprising in nearly all cases. Carbuncles, six cases, have in every instance been promptly helped. Five of our patients with boils or carbuncles were diabetics, and have shown good results except that the lesions were slower to heal.

Recently we have been injecting the filtrate directly into the boil, or into the base of the boil after inserting the needle through the normal tissue at the side. Needless to say this is a painful procedure even though a very fine and sharp needle is used. The results have justified the pain, however, as the action has been much more sure and rapid.

Boils in the nose and external ear canal have in every one of eleven cases been promptly helped when a tampon of absorbent cotton soaked in bacteriophage has been inserted and replaced at frequent intervals. Good results have also been obtained in two cases of stye.

STAPHYLOCOCCUS CELLULITIS. In four cases of staphylococcic cellulitis the results have been particularly good. The lesions were hard, red, sharply localized, extremely sore and painful. The patient in each case was carrying a temperature, and was worn out from loss of sleep. In no case did the lesion seem to be nearing the condition of suppuration. In each of the patients the temperature fell the next day after the bacteriophage was first applied, and the patient slept well that night. We vividly recall a colored man with a large angry mass in the axilla causing him to move with great caution and to carry his thumb in his belt to support the arm. He had scarcely slept for three weeks, and had been treated by a variety of methods of which none had given relief. We injected the material directly into the mass. He slept well that night, weeded his garden the next morning, cranked his car, and came into the laboratory twenty-two hours after the first application swinging his arm, and pretending to want to fight. The other cases were scarcely less surprising. A woman with two such areas gave negative cultures by aspiration of the inflamed mass twenty-four hours after the second injection of bacteriophage directly into it. Apparently the filtrate had sterilized the inflamed area, and as might be expected in such a case the healing was very prompt.

OSTEOMYELITIS. The results obtained in the treatment of this condition have been quite diverse. They have been disappointing for the most part when there has been dead bone in the lesion, as is of course often the case. In some patients the pus seemed to be checked but returned when treatment was stopped; in others there was little if any change. A diabetic with bone involvement showed satisfactory improvement, but the treatment did not prevent a new lesion from developing in an adjacent bone. Two cases with suppurating sinuses that were thought to have been caused by an osteomyelitis, but in which there was no bone involvement at the time of treatment healed completely in a few weeks though one had been running for seven years and the other for three. Two cases of chronic mastoiditis with marked bone destruction showed temporary improvement, but the condition returned when the treatment was stopped. In three discharging mastoidectomy wounds it apparently checked the pus, stopped the odor, and gave permanent relief. One child with an extremely bad infection of the mastoid improved very markedly, but died a few days later of an enormous brain abscess which had evidently been forming for some time.

Bacteriophage treatment is not recommended when there is a sequestrum. The necrotic bone must be removed surgically when this is possible. When the dead bone has been removed it is our belief that the treatment will help to control the infection and close the wound. In two such cases very good results have been obtained. In two other cases of multiple bone infection without operation there was apparently not the least improvement. Inasmuch as this method of treatment is one of local application it is to be expected that surface lesions rather than deep ones should show the best results. In reporting partial failure in the treatment of osteomyelitis we are merely adding one more to the long list of therapeutic measures that have failed in this most stubborn condition.

BED SORES. Bacteriophage will not prevent a bed sore, nor will it check in any degree the breaking down of the doomed tissue that has been devitalized by trauma, by decreased circulation due to pressure, embolus, thrombus or arteriosclerosis. It will, however, usually clean the wound of infection by the staphylococci and bacillus coli that are always present, and which complicate the lesion making it more destructive and offensive. It will nearly always stop the odor of such a wound; it will greatly check the production of pus; and if there is sufficient vitality in the surrounding tissues to fill in the gap it will make healing possible. Evidently nothing but the cells of the body can do the actual tissue building. In the few cases which we have seen several weeks or months after the healing was complete we have been greatly surprised to find that the scar at the site of the lesion in every case has been unusually soft and pliable. In case number five reported in a previous paper the scars of the two large bedsores were such that they could hardly be seen fifteen months after treatment, except that the one on the leg was pigmented. This man had been turned over to us when apparently in a hopeless condition. He was sixty-nine years old, had a severe cystitis, paraurethral abscess, septic infection, a high septic temperature, a suprapublic cystotomy wound, and two very ugly bed sores, one twenty cm. in diameter and the other ten by twenty cm. He began immediately to improve and went home well except for the large prostate. Last spring he put out a large garden, did heavy manual labor for a man of his age, and finally came back and had the prostate removed. His recovery from the last operation was uneventful.

We have repeatedly seen large bed sores become clean and granulate while the patient was dying of his primary condition—a broken back in two cases. One man dying of tuberculous meningitis had four great sores—two on each side—those on the right being worse. We chose to treat the worst two saving the other two as controls to be treated in the usual manner. Two weeks later the man died. It was evident that the sores on the side treated with bacteriophage were much better than those on the control side at the time of death. The bacteriophage used in all cases of bed

sores has been a mixture of the staphylococcus and bacillus coli strains, for the reason that both kinds of organisms are always present in the wounds. The bacteriophage suspended in a soft agar jelly has been found to be more convenient for such cases than the liquid. The jelly is simply spread upon the gauze dressings and applied directly to the wounds. In all cases pressure has been removed from the sore when that has been possible. In eight of the ten cases which have been treated for as long as five days we have seen improvement of considerable degree. In the other two, one had a diagnosis of syphilis with breaking down gummata, the other was in a boy extremely ill with staphylococcic septicemia, as diagnosed by repeatedly positive blood cultures. These cases were not improved.

Leg Ulcers. Two cases have been treated. In one case an old woman had had varicose ulcers for many years; she despaired of cure and had come into the city hospital for amputation of the leg above the knee. Various remedies were used in the attempt to avoid the necessity of amputation, but without result. Bacteriophage was used and after ten days the ulcers were both clean, and skin grafts were done. The smaller sore had a one hundred per cent take, while the larger was seventy-five per cent successful. She went home completely healed a short time later. A girl of twenty-three with leg ulcers of seven years standing had complete healing after about six weeks of phage treatment.

Suppurating Wounds. The more pus there is in the wound—provided it is the typical staphylococcus pus with no bone involvement—the more assurance we have that the result will be good. Dirty, pus-filled wounds have practically without exception healed rapidly. Some of these patients have complained that the filtrate has caused a burning or stinging sensation. In every such case we have had a brilliant result. As a rule, however, the patients have repeatedly remarked that the preparation was most soothing. A diabetic with an enormous slough involving the scrotum and the perineum invariably expressed great relief when it was used, and dubbed the preparation "Oil of Joy". He went home completely healed. The day after we began using it he slept nearly all day having had very little rest for several nights.

Abscesses. Abscess cavities when irrigated with the preparation have regularly shown less pus and odor, and have tended to heal rapidly. In cases with unopened abscesses we have repeatedly injected the bacteriophage directly into the cavity or into the indurated mass, and have seen the lesions disappear in some early cases, or more commonly, rapidly come to suppuration. The pus subsequently evacuated has been very thin, and in the three cases in which it has been cultured has been found sterile. Probably our most striking case is that of a Mrs. H. who was in a most desperate condition. She had one abscess between the sacrum and the skin that was eleven inches across in its smallest diameter. There were also other large and small abscesses. Her general condition was very bad and it was considered impossible for her to recover. Her improvement began the next day after the bacteriophage was begun, though she had been going down for weeks in spite of three blood transfusions and every other sort of good treatment. Three transfusion wounds had been open for weeks, and yet when phage was injected into an unopened abscess on the arm the pus speedily became liquid, and five days after evacuating an ounce and a half of pus the abscess was completely healed without soreness, redness or induration. She is not only alive but well at the present time, ten months later.

Appendiceal Abscesses. We attacked this particular kind of lesion with much reluctance. Probably our most striking case was one described before the Grant County Medical Society as being quite hopeless. A girl of ten was first seen by a physician four days (probably) after her appendix had burst. Operation was done, and a large appendiceal abscess drained. She improved for a few days and then began gradually to go down. There was a fecal fistula, and a very large amount of fetid pus. Temperature was 104-105, and the child was evidently in a most grave condition. It was predicted that she would die in a very few days. Mixed coli-staphylococcus phage was begun. The following day there was definite improvement, and a few weeks later she was well. We have had eleven similar cases though few were so definitely moribund. It is the impression of the internes and the resident at the Riley Hospital that these cases have done remarkably well, and that some have been saved from exodus by this means. All except one have cleaned up promptly and have healed in less time than was expected. The one fatal case had bacteriophage first used when evidently moribund with general peritonitis, and cyanosis of fingernails and lips.

Staphylococcus Septicemia. We have had two cases. One went ahead and died as if we had not been treating him. The other also died but lived much longer than was expected. The phage seemed to help some of his many lesions but had no effect upon the systemic infection, he having continued to have positive staphylococcus blood cultures. He received the filtrate on his sores, in some of the abscess cavities, and subcutaneously. The fact that the material contains proteins and peptones made us afraid to inject it intravenously, though it might have been worth the risk in his most grave condition.

Acne. Our experience with acne has been both gratifying and disappointing. Severe cases with many definite pustules have nearly always given

great improvement, and have usually been cured. The student body is familiar with certain of these cases and will vouch for the marked improvement in appearance. Moderate cases have usually been helped somewhat; mild cases have rarely been helped. This may seem at first thought to be a strange conclusion, but it may be that a case is mild because the individual has developed his own bacteriophage, and consequently phage produced in the laboratory is no new addition to the experience of the germs causing the condition. On the other hand the bad cases may be bad because the individual has not been able to develop an active phage. In such a case the introduction of an active strain from a laboratory source makes a new factor and improvement results. For the most part we have recommended that our cases get x-ray treatment after the more acute manifestations have been cleared up. This is for the purpose of causing a moderate atrophy of the sebaceous glands producing the oily skin so often underlying the condition. All of the complete cures have been permanent—with the help of the x-rays—to date. Acne rosacea was not helped in the one case treated. Cases with indurated lesions have shown some improvement. Several of these patients have insisted that the skin became softer and the lesions less painful after a few applications. Several of our cases of acne have been treated at a distance, the material being sent to them by mail. This has not been satisfactory except in two cases. Twenty-six cases have been treated with the following results: Thirteen splendid, seven fair, and six failures.

At least a dozen of our patients who are now alive and well were considered to be hopelessly ill when we began treatment. Many others were certainly dangerously sick. We are quite familiar with the fact that not all hopeless cases die under other systems of therapy, but we do sincerely believe that this treatment has saved several lives. One of our most striking cases is that of Miss Ho. About two years ago she was operated on for tuberculous peritonitis. A fecal fistula developed. She was better and worse at times, but finally sent home from a certain county hospital to die. About a year ago she came to the Long Hospital in a desperate condition. She was treated by various accepted methods, but grew worse in spite of all therapy. Finally it was decided that she should be sent home since there seemed no possible chance for her. At this time she was turned over to us for phage therapy. She was running a high temperature, was extremely emaciated, was in coma, delirium or a psychotic state practically all of the time. She was eating almost nothing, and was being kept alive by daily intravenous dextrose injections. Her wound was about three inches in diameter, was constantly full of foul pus and fecal material, and was undermined at the edges as far as the index finger could explore. The opening into the bowel was large enough to admit the index finger, and practically all of the bowel material was coming out into the wound. After a few days there was noticeable improvement, but even after six weeks when shown to the senior surgical clinic was declared in positive terms to be hopelessly ill by one whose opinion is considered to be the best. Today she is only one pound under normal weight for a person of her height, has a good appetite, good color and high spirits. The lesion is still uncovered with epithelium in part being about ten or fifteen per cent of its former size. The edges are no longer undermined. The fecal fistula has been closed for weeks, and the wound is perfectly clean. Recently a number of small skin graphs have been made on the site and two of them took. Inasmuch as there is no longer evidence of infection the purpose of the phage has been accomplished. The healing is delayed because the sluggish granulation tissue has not been able as yet to close the gap left.

We have been very anxious to get this method of treatment out of the laboratory stage. It is quite impossible for our small laboratory to meet the demands which have been made upon it. Can a stock preparation be made that will give comparable results? The advantages of the stock preparation are apparent in that the phage can be obtained without waiting for from two days to a week as is necessary in the case of the autogenous preparation. Furthermore, a few patients only can be served by the autogenous product because of the expense and the inaccessibility of laboratories equipped for the purpose. We have supplied the Swan-Myers Company with various strains of the organisms, and the homologous strains of bacteriophage, and they have been able to make a stock preparation which seems to be just as good as the autogenous in most cases. The company has supplied us with hundreds of ounces of the preparation quite gratuitously and this has made possible the large number of cases which we have treated. The stock phage is available in the form of filtrates of lysed cultures of staphylococcus, bacillus coli, and a mixture of the two. In case the stock preparation is used and found inactive we are very anxious indeed to obtain cultures from such cases, and determine if the stock phage is active against the culture in vitro. In case it is not so we shall attempt to find an active strain and introduce it into the stock filtrate. In two cases we have found that the stock preparation was not active against the particular strain of staphylococcus causing the trouble. We hope that this difficulty can be corrected in most part at least.

The use of bacteriophage in the treatment of infections is in its infancy and we ask the indulgence of the profession while it is struggling about trying to find its legs.

Summary

1. Bacteriophage treatment offers very attractive possibilities for the treatment of the various staphylococcic lesions when the bone is not involved nor the blood stream invaded.

2. Bacillus coli infections have yielded for the most part, but are perhaps not so amenable to this method as are the staphylococcus lesions.

3. The stock preparation which we have devised seems to be just as effective as bacteriophage strains developed against autogenous cultures and proved active in the culture tube, except that it does not "hit" so often.

4. Inasmuch as the method of utilizing this agent is rather different than is generally practised it may be expected that better results will be obtained after the practitioner has had some experience with the agent.

PHYSIOTHERAPY

(CONCLUSIONS FROM A STUDY OF SIX HUNDRED TWENTY-SEVEN CASES)

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Physiotherapy is an old phase of medicine which in the past few years has had a marked development through a more exact study of the different methods of treatment and through more refined means of application of these methods. Hydrotherapy, electrotherapy, thermotherapy, massage, and passive and active exercises were not unknown to the general practitioner of many years ago. The hot foot bath, the static or galvanic current, the hot cloth or lamp and the rubbing of parts, all are to be found in the armamentarium of our medical forefathers. What is now being called physiotherapy is not new but merely refined to a higher degree.

The general principles of modern physiotherapy are well known to the physician and to the surgeon, but unless he has had an opportunity to use this phase of treatment he is for the most part somewhat at loss to know just which type of case requires physiotherapy or what kind of physiotherapy may be of the greatest value in a particular case. Unfortunately the manufacturer of the newer instruments, especially those of an electrical type, have been over-enthusiastic as to the results that may be obtained and have, in our opinion which is based upon a study of our end results, made claims which were not justified. Perhaps they may have been led astray, in part, by the over-enthusiastic physiotherapist who failed to make a careful study of his own cases or came to conclusions from the treatment of a single case. It can be stated definitely that the field of physiotherapy is large and that many pathological conditions can be benefitted greatly by the right type of treatment, but it can also be stated with equal emphasis that many of the conditions which the over-enthusiastic manufacturer almost guarantees to cure are not helped in any way whatsoever by physiotherapy. In other words, physiotherapy can never completely displace medicine or surgery, nor is it a panacea for all aches and ills. It has real value but also real limitations.

In order that the general physician, the internist, and the surgeon may be aided in obtaining a better understanding of the value of physiotherapy, and also may be assisted in crystalizing his viewpoint as to the selection of cases in which physiotherapy is indicated, the analysis of six hundred twenty-seven cases treated by the writers have been made. These cases have been referred by either a physician or a surgeon, and their diagnosis has been taken as such.

The end results have been divided into three groups: Good, fair, poor, or no result. It will be seen that in some conditions the percentage of good results is so great that one may with confidence advise the treatment. On the other hand, some conditions have given such poor results that one may advise against the treatment, and there remains a group in which the results have been so uncertain that the patient should be told that he cannot expect too much but that the treatment is given only on a fifty-fifty basis. The cases will be considered in groups under the heading of the form of physiotherapy used.

DIATHERMY:

Back Sprains: One hundred eleven cases, seventy-seven good result, twenty-nine fair, and five no result. These cases represented sacro-iliac, lumbo-sacral strains, as well as those of the lower back muscles alone. In practically all the physiotherapy was only a part of the treatment, being combined with rest and fixation. A careful study of these injuries must be made and appropriate orthopaedic treatment given. Back strains cannot be cured by diathermy alone but can be greatly helped.

Joint strains: Three hundred eighty-five cases, two hundred fifty-four good results, twenty-six fair, and five no result. These strains were those following dislocations and subluxations. The deep heat gave not only relief from pain but apparently lessened adhesions and helped restore function. It had a distinct value in this condition.

Fractures: Thirty-six cases, thirty-four good results and two no result. These cases all represented slow or delayed union, and compared with other cases there seems to be a definite benefit in the use of the diathermy. It must be remembered, however, that not infrequently these cases of delayed union seem to take on a sudden repair, and

it is difficult to exactly state the effect of the diathermy. The same is true of fresh fractures, as here too we have such a wide range of limits for the healing of the fracture. It is the writers' opinion, however, that the callus formation is hastened by the use of diathermy.

Bursitis: Forty cases, thirty good result, and ten no result. This type of case is a most striking one. If the case is treated early, before the sac wall has become thickened, a complete cure should be obtained. The result will be observed within one or two weeks, at the end of which time operation should be advised if the fluid is still present. The same is true of the swelling associated with sprains about joints, and also the so-called simple synovitis cases. In the latter as a rule one will find some hemorrhage if the joint is aspirated.

Subdeltoid calcified deposits: Five cases, four good result, one no result. In all of the cured cases not only have the symptoms of pain been relieved but the deposit has entirely disappeared as shown by the x-ray. It is true that many of the deposits disappear without any treatment, but our experience has been so striking that a very definite value can be expected in this type of lesion. Certainly no case should be operated without first being treated with diathermy.

Tenosynovitis: Thirty-eight cases, thirty-eight good result. In all of these cases, rest by means of some fixation was used. However, the pain disappeared much more rapidly and the patient was cured more quickly with the use of diathermy, and it is our opinion that in this condition such form of physiotherapy is indicated.

Contusion to muscles: Sixty-three cases, fifty-three good result, eight fair, and two no result. Here again as in fractures it is rather difficult to estimate the true value of diathermy. However, one of the writers (Harcourt) has seen a great number of contused wounds, and it is his opinion that there is a more rapid absorption of the hemorrhage when diathermy is used.

Myositis: Seven cases, five good result, and two no result. Here again we have in part an inflammatory exudate (those cases resulting from exposure) and in part a hemorrhagic infiltration (rupture of the muscle) and the effect of the diathermy is apparently to hasten the absorption of the exudate.

Nerve Contusions and Neuritis: Twenty-seven cases, seventeen good results, ten fair. In the simple contusions it is to accelerate the absorption of the hemorrhage. Six cases of so-called neuritis have been treated with most astonishing results. These cases complain of a more or less constant ache over a large area which does not correspond to any nerve distribution. The pain is made worse by cold, and their only relief is through the use of heat, but as a rule is only temporary. The upper extremity is most frequently affected, and the forearm is the more common site. The shoulder and the lower extremities have been involved. It is the opinion of Mumford that in this type of case the lesion is not one of the peripheral nerve trunk or its distribution but is that of the sympathetic system which causes a partial narrowing of the arteries through a spasm of the muscular coats. In these cases relief should be obtained with but three or four treatments of the non-vacuum electrode. In all of the cases the relief has been permanent.

Chronic Arthritis: Seventeen cases, five good results, nine fair, and three no results. In this type of condition the use of diathermy is perhaps of but little value. No change in the actual condition can be expected, and the x-ray will not show any improvement. One may give some relief from pain but it is perhaps temporary and cannot be expected in all cases.

Ultra-violet light is perhaps the most used modality of physiotherapy. Its contra-indications are few; its usefulness covers a very wide field.

In the period covered by this paper we have had a total of four hundred sixty-two cases, referred to us for this light therapy. These cases all have been treated with the air-cooled quartz light. The diagnosis of the condition for which they were referred, together with the results as observed by the referring physician and by us, may be tabulated as follows:

	283 cases	260 good	18 fair	5 no result
General Tonic				
Neuritis	16	10	4	2
Skin affections	11	4	5	2
Acute respiratory not T. B.	12	11	1	
Chronic nasal sinus	6	6		
Acute coryza	17	15	2	
Adenitis not T. B.	9	7	2	
T. B. Peritonitis	5	5		
T. B. of carpels	5	5		
Scar tissue	4	3	1	
Non Union	7	6	1	
Local:				
Osteomyelitis	14	14		
Paronychia	4	3	1	
Leg Ulcers	10	9	1	
Other Infections	59	57	2	

General Tonic: Some of these cases were referred with such diagnoses as debility, anemia, asthenia, following post-operative or post febrile disabilities. The quartz light effect was as beneficial, was more dependable, and was more pleasant to take than any tonic for oral administration.

Chronic respiratory conditions were the diagnoses on another large group referred for general tonic. In these conditions we found the cough lessened, the color improved, and the weight increased quite constantly within a week after beginning treatments.

Malnutrition of children and infants is included in this general tonic classification. The results in this condition have been exceptionally satisfactory when combined with proper diet.

Those cases diagnosed as neuritis presented symptoms varying in character. Some of these complained of burning, itching, or pains of lancinating character corresponding to the distribution of a peripheral sensory nerve. Of these two had herpetic lesions on the same area. Others complained of dull constant aching involving an anatomical area such as the upper arm or the leg, but not limited to the distribution of sensory nerves.

The skin affections for which quartz light was prescribed included three cases of Rosenbach's erysipaloid; in each case the area involved was limited to one hand. Three very similar cases of the same infection were observed during this same period. The cases treated by quartz light locally cleared in from seven to ten days. The three cases treated with hot packs alone cleared in two to three and one-half weeks.

There were also several cases of eczema included under this heading. In only one case was the quartz light the sole form of therapy. This case was an acute rapidly spreading vesicular-pustular lesion, involving the nape of the neck, bearing rather close resemblance to eczematoid ring worm. This lesion under close prolonged quartz light therapy daily was cured in five days.

In alopecia, also classed in this group, results have not been satisfactory. When seborrheic dermatitis of the scalp was also present, this condition was markedly benefitted, but prolonged treatment (in one case over three months) resulted in no apparent new growth of hair.

Non-tuberculous, acute respiratory, conditions responded very favorably to quartz light. Non-productive cough, the most distressing symptom reported by each in this group, was alleviated in from one to four treatments. Under quartz light therapy these cases gained weight and stopped coughing. In four of these cases, all children and asthmatics, the "pipe organ" rales disappeared after treatment of about a month's duration.

The quartz light was used as an adjunct to local treatment in the six cases of chronic nasal sinus infection. In all six the attending physician felt that recovery was hastened by the tonic effect of the treatments.

In seventeen cases of acute coryza, fifteen were well within four days; two cases were benefitted but not cured.

Seven fractures with non-union treated, resulted in prompt calcification in six, no benefit in one.

In infections the quartz light was applied locally, after drainage was established in osteomyelitis, as early as possible in other conditions. The results in the table demonstrate its efficiency in these conditions.

This observation was made in the treatment of leg ulcers and other granulating surfaces: Prolonged radiation, i. e., beyond five minutes, resulted in greying of the granulation tissue and increased "lymphadesis" with apparent retardation in healing. Doses of shorter duration, however, stimulated granulation tissue, and hastened epithelialization. This, in our opinion, may be due to the fact that, when the pigment layer of the skin is absent the underlying tissue, without the defense of pigmentation, may be destroyed or injured by prolonged radiation.

THE RELATIVE VALUE OF SYMPTOMATOLOGY IN DIAGNOSIS OF DISEASES OF THE URINARY TRACT*

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Surgical operations on the urinary tract are recorded in the earliest medical writings; but our knowledge of diseases of the urinary organs dates from the discovery of the cystoscope by Nitze. As this instrument was perfected, and as the accessories for intravesical manipulation through it increased, not only did our familiarity with urinary pathology grow but with the physiology as well. Among the more important discoveries in the line of accessories is the ureteral catheter which enables us to study both microscopically and bacteriologically the separated urines as they are obtained from the respective kidneys and in that way determine which side is the seat of the trouble. We also can determine the relative function of the kidneys.

Prior to the introduction of the ureteral catheter attempts were made to study the ureters radiographically by the introduction of opaque bougies. This method proved of very little value. Later, however, pyelography was attempted by the injection of opaque materials into the kidney pelvis, the best of which, at that time, was found to be colloidal silver. Its use was very dangerous on account of its toxicity, and deaths following the procedure were not at all uncommon. There followed in succession a number of different substances used for this purpose, and although there was a great reduction in the danger following their use, it was not until the introduction of sodium iodide as the opaque medium for pyelography, as suggested by D. F. Cameron, that this means of study was made really safe. Today there are few internal organs that can be studied as thoroughly and with such gratifying results.

Having at our command such excellent means of investigation and study we should expect the

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number of cases with long-standing urinary disorders to be reduced to a minimum. Experience, however, proves that this is not altogether true. Excluding those patients who try every form of kidney pills over a period of months or years before consulting a physician, there are some remaining who see their doctor early and yet go on to a chronic state of affairs with irreparable damage, perhaps, to their kidneys or bladder because of the delay of early and systematic study of the condition. The reason for this, I believe, is twofold. The first I shall mention briefly; the second I shall consider in detail.

First of all there are still some very definite prejudices against cystoscopy and pyelography due, undoubtedly, to the unfavorable impressions remaining from the early days. However, these prejudices do not hold good today. In fact, when properly carried out the procedure is certainly no more dangerous than the intravenous injection of the dye for gall-bladder study which is carried out almost routinely in many clinics and by many individuals; and from the standpoint of information derived much more positive than cholecystography. Since the use of sodium iodide has been introduced no untoward results have been reported even by those men who practice bilateral pyelography as a routine procedure, which method, by the way, should be the usual one in order to avoid misinterpretation in the bizarre forms of normal pelvis which are not uncommon.

Another objection occasionally heard is the possibility of carrying infection from the bladder to a previously uninfected kidney. This objection is more theoretical than actual, although it might hold when there is obstruction to the urinary outflow on that side. In that case the information derived is certainly worth the risk.

The second reason, is the answer to the question, "What is the relative value of symptomatology in the diagnosis of urinary disease"?

Teaching may have changed within recent years, but not very long ago students were taught that kidney stones, for example, cause severe colic which begins in the loin and radiates down the thighs and toward the bladder, and that blood or pus or both are present in the urine; that pyelitis causes pain in the back and fever and so on.

It would be a problem very easily solved if the various diseases corresponded to the text-book descriptions. Unfortunately, however, the symptoms in many instances are not typical and do not conform to what would be expected of them. Let us consider kidney stone for a moment.

In reviewing a series of cases of calculi in the urinary tract Braasch remarks that the typical symptoms are absent in about half the cases. The location of the pain is often in the anterior lower or middle part of the abdomen. Almost one-third of the patients with stone in the right kidney had the gall-bladder or the appendix or both removed without relief. He points out, therefore, the importance of studying the upper urinary tract in all cases of abdominal pain when it is not typical of a specific intra-abdominal lesion. We might say that of other conditions of the urinary tract as well. It should be remembered that although the kidney and ureter are extraperitoneal, the relationship between them and the intraperitoneal organs is very intimate; and it is not uncommon to have a hydronephrosis which is not large enough to be palpable and which does not give the usual picture, cause a train of gastro-intestinal symptoms which would lead us to suspect some serious trouble with the latter. As a corollary, therefore, we might say that every case with gastro-intestinal disturbance the cause of which is not clearly evident, should have the urinary tract investigated. Not until we are thoroughly aware that these cases can and do exist will they be kept out of the classification of the neuroses.

While we are on the subject of related organs I want to point out the importance of studying the urinary tract in women with pelvic diseases when there are definite symptoms of urinary disturbances. We do not deny that prolapse, cystocele and other conditions cause disturbances in this function; yet, in a good many cases these symptoms deserve special consideration before too much is promised from operative relief.

Let us now consider the chief urinary symptoms and see how they are of help to us in the localization or diagnosis of the trouble.

The important symptoms in urology are: hematuria; pyuria; pain; difficult urination; frequent and painful urination.

Hematuria. By this term we mean either macroscopic or microscopic blood in the urine, and, for clinical purposes, a convenient division of the various sources of the blood is as follows:

A. Systemic causes: Hemophilia; hemorrhagic purpura; leukemia; scurvy; Hodgkin's disease.

B. Lesions of the viscera adjacent to the urinary tract; appendicitis; tubal diseases in women.

C. Lesions of the urinary tract proper. These are responsible for more than two-thirds of the hematurias and are divided about equally between the upper and lower parts.

1. Lesions of the upper urinary tract causing hematuria are: polycystic kidney; tuberculosis; movable kidney; neoplasm; calculus; pyelitis.

2. Lesions of the lower urinary tract causing hematuria are: neoplasm; adenoma and carcinoma of the prostate; calculus; simple or tuberculous ulcer; acute or chronic cystitis.

One factor may help us differentiate bleeding from the kidney and ureter from that of the bladder. If the blood clots on its way through the ureter there will be an accompanying colic on the same side. Without clotting there is an entirely painless hematuria, and it is impossible to tell whether it comes from above or below. An ordinary radiographic film will help rule out calculus as a possible cause, but the absence of a shadow is not positive proof that stone is not present, because from ten to fifteen per cent of stones cast no shadow. It is needless to add that every case of hematuria should be investigated during the active hemorrhage.

Pyuria. Some maintain that a normal urine should be pus free, but in general five to seven cells per field in a centrifuged specimen is not considered abnormal. The sources of pus in the urine are:—

A. Urethral and paraurethral.
 1. Urethral infection, specific or non-specific.
 2. Prostatitis and seminal vesiculitis.
 3. Periurethral abscess.
 4. Stricture.

Infections of the anterior urethra offer no particular difficulties. Those in the posterior urethra, with much pus draining backward into the bladder, may cause confusion occasionally.

B. Renal and Ureteral sources.
 1. Pyogenic infections.
 2. Tuberculous infection.
 3. Calculus.
 4. Ureteritis.

Here, as in the cases with hematuria, pain and intermittent attacks of colic may give us a clue to the seat of the trouble. In the acute cases, and in the chronic cases with obstruction to free drainage, fever is usually present. Others give no indication as to the source of the pus. Tuberculosis of the kidney causes no rise in temperature, nor is the absence of the tubercle bacillus in the smear positive proof against tuberculosis infection. Renal stones may or may not be accompanied by pus and very often cause no pain whatever.

Until recently it was taught that it is possible to differentiate upper from lower urinary tract infections by finding in the former certain types of epithelial cells. Another point of difference was the presence of pus cells in clusters or singly. These ideas have been proven without foundation and have been discarded as diagnostic aids.

C. Vesical sources.
 1. Acute and chronic cystitis.
 2. Diverticulum.
 3. Stone.
 4. Fistula with intra-abdominal organ.

Cystitis is rarely a primary condition, and such a diagnosis has about as much meaning as a diagnosis of "headache". Bladder infection is so often secondary to infection of the kidney that evidence of the one should make us suspicious of the presence of the other. Infection of the bladder may be caused also by an extension backward of an infection from the posterior urethra.

Predisposing causes to bladder infection are failure to nearly complete emptying of itself, as in prostatic hypertrophy in men and cystocele in women; trauma from instrumentation or other causes; atony of the detrusor of congenital type; pregnancy; calculi and tumors.

Stone: The same factors that predispose to infection also predispose to stone formation. Very few bladder stones have as the nucleus a small stone passed from the kidney.

Diverticuli: The only symptom in this condition is often a painless pyuria.

Pain: Renal pain is of two types—the colicky, severe type, and the dull constant pain in the loin. The first is due to sudden obstruction to the urinary outflow. This is the typical pain described in text-books which begins in the loin and radiates to the thigh and bladder. When it occurs it is of significance in locating the side of the lesion. The dull aching pain is due to enlargement of the kidney with subsequent stretching of the capsule. The enlargement may be caused by a morbid process in that kidney or it may be a compensatory hypertrophy as a result of a diseased kidney on the opposite side. To rely upon this symptom, therefore, is extremely dangerous.

Difficult Urination: The most familiar causes of this condition are, of course, prostatic hypertrophy and urethral stricture. Additional causes are hypertrophy of the trigone or interureteric bar; median bar formation; contracture of the vesical neck; large diverticuli; tumors encroaching on the bladder neck and the neurogenic disturbances of the bladder muscle. Median bars, contractures, atonic bladders and valvular obstructions to the urethra may occur at any age, and special attention is called to this group as sources of persistent pyuria in infants and children.

Frequent and Painful Urination: Excluding polyuria, frequent urination is dependent upon the bladder capacity and the irritability of the base of the bladder and the posterior urethra, and can be reproduced by injecting irritating solutions into the latter. The amount of burning that accompanies urination depends upon the degree of inflammation and the acidity of the urine. As the process extends around the bladder neck there is more pain which increases still further with involvement of the bladder mucosa. In severe cases it amounts to a tenesmus or a constant effort of the bladder to empty itself.

Under each of the symptoms I gave a tabulated list of the conditions which may be responsible; and we can see at a glance how many different

conditions are listed under the same symptom, and how futile it is to try to form definite conclusions regarding the exact nature of the disturbance from that information. The difficulties are increased by the fact that physical examination, in so many instances, reveals nothing to help us. A prostate may not seem enlarged to the examining finger in the rectum, yet there may be enough intravesical enlargement to cause complete obstruction. On the other hand an individual in the prostatic age who has a palpably enlarged prostate may have all the characteristic symptoms that usually accompany the condition yet the prostate may not be the offender.

Laboratory procedures may be of diagnostic aid, but not always. For example, finding tubercle bacilli in the urine does not tell us whether they come from the kidneys or the genital tract. Nor is the functional kidney test, including examination of the blood for nitrogen retention products, of any particular value in unilateral kidney disease because the remaining good kidney takes on the added work and does it very efficiently.

X-ray as an aid in diagnosis is only of value when combined with cystography and pyelography. Even in cases of calculus the radiograph may increase our suspicions, but to depend on it for absolute diagnosis is dangerous because the shadows which we sometimes suspect to be stones turn out to be calcified lymph glands or other calcareous material. Only by the combination of the various means at our command — cystoscopy, cystography, pyelography, tests of individual kidney function and bacteriologic study—can we come to definite conclusions.

SUMMARY

In spite of the means at our command for studying the urinary organs many patients are seen with long-standing urinary diseases resulting in destroyed kidneys and very much damaged bladders. This is due to several reasons.

I. There still remains a distinct prejudice against cystography and pyelography which, with the present day technique, is wholly without basis.

II. (a) A large percentage of cases with urinary tract disease do not correspond with their text-book description hence go unrecognized for long periods of time. The upper urinary organs must often be excluded as causes of intra-abominal symptoms.

(b) For practical purposes it is safer to consider bladder infections as secondary to infection of the kidney. Universal recognition of this fact will bring about early and thorough study of these cases.

Only by the combination of cystoscopy, pyelography, cystography, bacteriology, excretory and retention tests can definite diagnosis be made.

TONSILLECTOMY IN PULMONARY TUBERCULOSIS*

WITH REFERENCE TO TECHNIC AND ANESTHETIC

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To be induced to do a thing because it is modern, or to continue a practice because it has the sanction of custom is incompetency. The majority of us are prone to do this. It is easier, and often profitable, to follow the direction of least resistance; to solve our problems by the opinions of others. The clinical reports of trained and competent observers, and the submitted findings of research laboratories must, of course, be given due consideration so that the reports may be analyzed and the findings corroborated, otherwise we would come to rely upon authority when in medical science there are no authorities. Change is too constant, and is brought about in such unexpected ways. Materia Medica is a panoramic mirage. Physiology is in its infancy; pathology is but little better advanced; surgery is subject to constant changes; only anatomy remains constant and it has its variances. Under such conditions it is illogical to assign authority to any man or group of men. Heywood Braun, in a recent article, unwittingly points to a constant change in medicine when he says, "By the time the doctor gets on to a new idea in medicine the damn thing jumps from under him." What is true of medicine is largely true in surgery.

In accord with other surgery that of the throat has experienced its changes. Consider tonsillectomies; how they have grown. Even Ford in all his magic growth has not surpassed this. The lowly tonsil was occasionally removed some centuries before Christ, but it did not come into full operative favor until about thirty years ago. Since then it has made incarnadine our surgery, and it has become necessary to check the red flow, both by a safer method of enucleation and a more conservative condemnation of this gland. But other changes have come upon us.

As late as 1783 Cullen was considered radical when he said, "One might scarify a tonsil to relieve quinzy." Sixty years later it became the practice to clip the large ones if not actively inflamed. The etiologic significance of an infected tonsil and the therapeutic value of its removal was not developed until quite recently and that is changing. A few years ago it was considered heresy to remove a tonsil in an active inflammatory stage, and yet, there is an increasing number of favorable reports from conservative, competent men on the removal of tonsils in acute peritonsillar abscess; follicular tonsillitis; Vincent's angina, and other acute and chronic ulcerative processes confined to the tonsil. It is impra-

*Presented before the St. Joseph County Medical Society, February, 1928, before the Welborn Clinic staff and visitors, May 16, 1928.

tical to make a lengthy compilation of these comments here upon this feature of laryngology. I will simply refer you to the journals of otolaryngology for the past ten years.

A long series of laboratory reports revealed the fact that the Klebs-Loeffler and tubercle bacillus were rather constant in the enucleated tonsils. The Mayo clinic reports that of the "pathologic examination of tonsils from ten thousand patients, which was completed about a year ago, only one-half of one per cent were found tuberculous. This is a marked decrease compared to our findings of twenty years ago, when the incidence was around four per cent." This is from a letter answering my inquiry of them recently. Crile's clinic, answering a recent letter to them, had no report to make as they do not do a routine section of enucleated tonsils, but said: "The Louisville City Hospital gave a report of three per cent tubercular."

Clinical observations disclosed the equally interesting fact that following the enucleation, tubercular ulceration of the denuded fossa did not follow and postoperative diphtheria was rare. A case was reported in the *Nebraska State Journal,* 1922. The operation was under local anesthesia. Dr. Beck, in a recent letter to me, says, "We always are sure we are not operating on an acute infectious condition." Consideration of these findings, and reports of some war surgeons upon other suppurative and inflamed glands of the body, led to the above stated practices by a few otolarynologists.

Formerly, no operative procedure of any sort would be considered in pulmonary tuberculosis. This was especially true among laryngologists as well as among those specializing in pulmonary tuberculosis. There is still some difference of opinion. The literature gives only references here and there to tonsillectomy in pulmonary tuberculosis and opinion is divided somewhat; but coming more and more to a consideration of tonsillectomy as a therapeutic measure. Replying to my letters sent out recently Professor Nager, of Zurich, said, "To now, tuberculosis was no indication for removing tonsils." Pollock of the Beck Clinic, Chicago, said, "I am in favor of removing tonsils in every case of tuberculosis and see no reason why it should not be done as it removes one focus of infection." Dr. Moore, of Akron, Ohio, says, "Dr. Hyde, our expert on tuberculosis and superintendent of the sanatorium for tuberculosis, advises removal of tonsils before admission and often after admission." The text books on otolaryngology have little to say upon the subject. The magazine articles while abundant as to practically every other phase of tonsil work only refer to it occasionally. In the literature on tuberculosis and its treatment considerable appears. Pottinger says: "We cannot deny that the tonsils and the lymphatic tissues of the pharynx bear an important relation to infection in tuberculosis, the same as we know it in other infections." Hayden *Annals of Otology* (December, 1927), says, "The structural changes in lungs may be beyond repair and of so serious a nature as to make the local lesion a minimal part of the clinical picture." Here it is often unwise to stir up these foci. Tucker, in his thesis accepted by the Triological Society for admission, lists tuberculosis as one indication for tonsillectomy. Groeber, and later, some others, by smearing Chinese dyes on the tonsils demonstrated that the dyes followed the lymphatics to the pleura and apaces of the lungs, thus demonstrating this source of infection. Inferentially this points to the therapeutic value of their removal.

Others doing chest work have recently advocated the removal of not only tonsils, but other upper air passage infections in the treatment of these maladies.

There is such an overwhelming evidence that the tonsils are an important avenue of infection; that they carry such a varied assortment of microorganism, one is forced to the conclusion that they contribute not only directly to infections of various sorts, but, by reason of the absorption of the proteid emanations of the pathologic organisms and the various pus germs themselves contribute to a lowering of resistance to disease of all types. Following removal the nearly constant findings have been one or all of the following results: increased bodily tone; improved appetite; increased assimilation as shown by increased weight; and in case of infection, either by "colds" or the eruptive fevers, a milder reaction, showing the resistance to these diseases greatly increased.

Since the treatment of pulmonary tuberculosis is directed wholly to the effort to build up the bodily resistance to the infection, it becomes a prime measure of the therapeutic regimen to not only supply the sanitary conditions best suited to the case and the nourishment required to build them up; but those conditions that are found to lower the resistance to disease and generally interfere with assimilation and bodily vigor must be removed. The recognition of these facts is why the profession is coming to advise removal of all these foci of infection, and also the correction of nasal obstructions in pulmonary tuberculosis.

To get a personal slant upon the subject and as a cross check to the papers published, I wrote to ninety specialists and sixty-two replied. Nine were doing eye work only. Eleven were noncommittal. Ten were against removal of tonsils in tuberculous cases with a few of these giving modifications. Nager, for instance, says simply, "To now it is not considered advisable", predicating a probable reconsideration upon his part. Freeman Adams (Roosevelt Clinic, Seattle, Washington) says, "I have always removed infected ton-

sils in pulmonary tuberculosis either active or quiescent—results have justified me sufficiently to continue the practice." T. W. Lewis (Shambaugh's Clinic, Chicago) says, "The other (tuberculous) conditions can but be benefitted by removal of infected tonsils." Beck, *Applied Pathology*: "In cases of large or infected tonsils of a tuberculous patient whose sputum is ladened with tubercle bacilli, but whose general condition is good, we have removed such tonsils under local anesthesia with definite benefits."

Ridpath says, "No", in active cases. Quiescent cases, I judge, he considers operable. R. H. Skillern says, "only in quiescent cases." Dr. S. R. Skillern says, "I believe in removal of tonsils in tuberculosis, if gotten in early states or in quiescent state." Twenty-two were in favor of it. Of these some were modified to include only quiescent cases and some are guided by the internist. The preponderance of opinion is now favoring these operations both among the specialists and those treating tuberculosis camp, (*London Lancet,* March, 1922), says: "In a group of cases operated on, seventy-two per cent showed marked improvement. None showed any demonstrable non-effects." It is assumed no operation would be considered in advanced cases. There is quite a wide divergence in this classification, however. The mildly active, advanced active, fulminant and the interstitial or what was formerly called chronic interstitial pneumonia, and miliary tuberculosis, would have to be considered separately. Naturally, the internist or tuberculosis expert would be called to classify. To quote from many of those objecting to operations and from those approving operation, the recurrent statement was, "Individual cases would have to be studied." This should be the rule, however, in any branch of surgery.

In a review of all replies and a check over of the literature there was no positive data against tonsillectomy except in two replies. One noted rapid decline after the operation and one a flare up of a quiescent case. What the circumstances accompanying these conditions were is not stated. Of the negatives and their qualifications there is a large element of evident traditional or group thought and one, at least, judging from his replies to other questions, is mostly an advocate and not an observer. Of the positive ones there are some qualifying statements, a larger part of which is trite, and some also of group thought, which will be referred to later on in another phase of this paper. The majority of them, however, advocate removal in quiescent cases only. In a review of the replies there is insufficient evidence of ill effects following the removal to offset the positive gains reported. The logic of the situation, therefore, favors removal. Having decided upon the advisability of removing the tonsil two other questions immediately present themselves for answer. The first is the technic to be used and the second the anesthetic to employ.

Manifestly in these cases the method to be employed is of the greatest importance second to the anesthetic. Any form of application of x-ray and radium has proven unsatisfactory as they not only do not destroy the tonsil nor its contents, but cannot be controlled in reference to the surrounding tissue. Wells, in his report in September in 1923 (*Laryngoscope*), concludes that the reason for x-ray's failure to produce satisfactory results upon the tonsil is due to the impossibility of applying sufficient dosage without injury to the surrounding tissue. He found no change in the bacteria nor in the tissues of the gland. In his experiments with radium he found some atrophy of gland and lessening of the bacterial flora. No claim was made of removal of the gland. This method requires special needle, several sittings at wide intervals and great care must be observed to avoid burning. In 1921 Weatherbee reported some results from x-ray, but in 1922, both Coakley and Babcock made a careful investigation and reported adversely to this. Their work corroborated Wells. Beck in his "Applied Pathology" says, "In that form of hyperplasia where there is no infection in the crypts there is no doubt that the reduction of the lymphoid tissue can be accomplished by the employment of radium or x-ray—whereas in that form of disease in which the infection and degeneration play a part the cure of any such condition cannot be expected and surgical interference must be employed."

In two cases under my observation that had been reported successfully removed by x-ray, I had to remove the tonsils. Both were markedly infected. The nature of the flora was not determined. One side was slightly scarred over, whether by x-ray burn or not I could not determine. According to the report of Clark, of Philadelphia, and McClain, of the North Carolina Sanatorium, tubercular ulcerations of the tonsils may be successfully treated by x-ray. Sloughing, however, is reported in some cases. Repeated sittings are required. The x-ray and radium had a short run of hopeful results, but soon began to show their hindrances and defects. They still have some adherents. I find, however, the reports of competent observers so adverse to both x-ray and radium that it is hardly worth while giving them further consideration. So, too, with the cautery in any form.

The ideal tonsillectomy is, of course, the desideratum; but, since that cannot be found the nearest approach to it should be used. Dr. S. H. Large (*Laryngoscope,* September, 1923) says, "The less the mechanical manipulation the quicker and better the healing." A close analysis of this statement will make it cover about all of an ideal

operation, since it would mean the shortest time consistent with good surgery, least trauma to pillars and surrounding tissue; minimum or no hemorrhage, requiring controls—certainly not ligation of bleeding points, and a minimum of post-operative hemorrhage or sloughing. To accomplish this is the aim of all operators.

In tonsillectomy as in any other field of surgery the individual employing a method or instrument is the determining factor in the equation. The fool-proof instrument or method has not yet been devised. And if it were, the time, or necessity for its employment would still reside in the judgment of the individual.

There are three general methods in use. First, the dull dissection and snare with its various modifications. Second, sharp dissections, either by scalpel or the Sluder, quick, sharp enucleation. The third is by dull enucleation and clamp as done by the La Force instrument. Of these the dull dissection snare is the most common. It has various technics of application and instrumentation. The Beck instrument is perhaps the most satisfactory.

Certainly the reports written and published credit it with the least amount of primary and secondary difficulties as compared with any other snare and dissection method. It has this undoubted advantage over the Tydings, for example, that it has a guard for the wire which controls its application and protects the pillars, if they have not previously been damaged by the dissection. This is the embodiment of Freer's snare wire guide devised twenty-five years ago. It never came into general use.

The second or sharp dissection as practiced for a while by the elder Ballinger and done with a scalpel has been superceded by the Sluder sharp, quick enucleation. It has the advantage over the snare of quickness and less trauma to pillars and peritonsillar tissue. It is very bloody and while little mechanical manipulation of the parts is required, the primary bleeding requires compression and even ligation of bleeding points much more often than the other plans. The amount of hemorrhage increases the shock; and, often the danger of aspiration of blood is greatly increased. The time of the operation is also increased, for no tonsillectomy can be said to be completed until hemorrhage is stopped.

The third method is by a dull dissection enucleation and clamp as done by the LaForce. The modified Sluder, clamping the vessels is but this method applied to Sluder's instrument. Because it was not the original idea of Sluder I have considered the two methods separately. While the principle of engaging the tonsil is the same in both, there is a wide difference in the final or end results. Sluder's cuts out the tonsil at once and the LaForce clamps all vessels and capsular tissue until the operator chooses to cut it off, thereby producing a bloodless operation and having only a slight oozing after the pillars separate, by this means shortening the time of operation.

The text books for the most part describe the snare. Being written primarily for the undergraduate students they necessarily make an arbitrary statement of the authors' views and preference method. The journals are replete with the various plans. Only one differential comparison has been made. Ballinger in reviewing some thirty thousand cases with a criticism of his scalpel operation found that two septic infections followed the operations—one from his scalpel enucleation and one from wire snare—the worse from the sharp dissection. Dr. Israel, of Houston, Texas, made a laboratory investigation to determine the amount of muscle tissue removed and the remnant left of the tonsil by the various methods. He confuses the La Force and Sluder. His deductions from the laboratory reports are illogical. The value of his findings might be confined to this, that the tonsil has little capsular tissue and contains some striated muscle tissue. In fact, Howard R. Ball, (*Annals Otol.*, December, 1924) says, "Striated muscle is not infrequent in the capsule and extends along the trabeculas and is even found in the lymph follicles." Dr. Patterson, of Knoxville, Tennessee, made a careful study of these technics. He concludes that the La Force enucleation has the advantage that it gives the least mechanical manipulation and is practically devoid of bleeding. It is as quick as the arterial occlusion will permit and is followed by less post-operative sequallae. My inquiry confirms Dr. Patterson's paper.

The instrument is not so much used as the others; but the report of those using it corroborates Dr. Patterson's paper. Both the Skillerns and Ridpath report a fifty per cent less bleeding and a quicker recovery. Sewell, of the Manchester University, after using it six months following my demonstration of it at the Royal Infirmary, in Manchester, reports very much less hemorrhage and a more satisfactory recovery. Add to this the suction which keeps all the mucous from the throat as well as cleansing of pus squeezed from the tonsils and one has a practically clean throat with as slight aspiration of foreign material into the bronchi as is possible. Since it conformed, in my hands, at least, to the conditions as laid down for an ideal operation, I use it in these cases as the operation of choice.

The third general question is: Shall a local or general anesthetic be used? To this practically all the responses were for a local with some few leaving me in doubt as to their preference. I found, though, no definite reasons further than a traditional practice concerning ether in any pulmonary involvement. I have not

considered chloroform as a general anesthetic because of its danger to the heart's action. This organ is already burdened in pulmonary tuberculosis and chloroform's action is so devoid of warning I've come to fear it. Perhaps my reasoning is another form of group thought. The literature is too voluminous to quote, and rather sketchy in its reference to ether on the living tissue; but Hatcher's report in the *Journal of the American Medical Association,* December 19, 1927, throws some suggestive light upon it. A. H. Miller's article in the *R. I. Journal,* December, 1927, reviewing five thousand cases of anesthesia under ether and gas oxygen demonstrated ether less dangerous than gas oxygen in the following: Production of coronary embolism, cerebral hemorrhage; seven times more frequent in gas oxygen. Both occurred in very small per cent of cases, however. Pulmonary embolism; œdema; pleurisy; pulmonary abscess and pneumonia all showed a slight per cent of occurrence over ether. Only bronchitis showed more frequent after ether. All these, however, are of so small a percentage of occurrence as to be negligible. Ether does produce more cerebral congestion than chloroform, but less than gas oxygen. The occasional accident of pneumonia following ether is not sufficient to deter its use when balanced against other methods and their sequellæ. Ether pneumonia is an unsubstantiated idea; previous to the discovery and classification of the pneumococcus, pneumonia following ether was attributed to its irritating effect upon the lung tissue. This has become the traditional or accepted opinion of the profession without further analysis —it is the group thought referred to. The only case I ever saw following ether anesthesia proved on investigation to be pneumonia of type 3. It recovered.

There is no anesthetic without danger. Ether has less to its record than any other. While it does increase the flow of saliva somewhat, it apparently does so by reason of relaxing the capillaries and there does not appear to be sufficient irritation to the bronchial and tracheal mucosa to show any increased secretion. Spasm is unquestionably relaxed. In tonsil cases, at least, the amount of time required is not great if the anesthetic is properly administered and no complications arise.

My search of the journals and text books revealed a great preponderance of reports to this effect; that in local anesthesia shock is greater; there is greater tendency to delayed hemorrhage; longer period of recovery; more discomfort following the operation, and as to pulmonary complications, pneumonia was more frequent, pulmonary abscess more frequent and embolism of greater incidence. There is greater discomfort during the operation and more difficulty in controlling any emergency that might arise with greater risk to the patient than under a general. Of all the questionnaires some few were enthusiastic for local anesthetic in all cases, claiming unusual results. Without intending to question the sincerity of their reports I felt compelled to make allowances for enthusiasm. Just so I had to make allowances for some who are unconsciously advocates of a technic rather than a cold observer.

With reference to complication and sequallæ following and during operations under local anesthesia, Drs. Ross Hall, S. R. Skillern and Dr. Ridpath, of Philadelphia, report: "Greater trauma, delayed recovery, more bleeding and greater shock." Carmody, referring to local anesthesia, says, "Abscess from infection being carried in by needle, severe pain following operation, sloughing of pillars, pulmonary abscess from aspiration substance because of motor paralysis of base of tongue and anesthesia of vertricular bands." He reports a case of hemorrhage of bowel following local anesthesia. Whether attributable to that or not, cannot be said. Beck, in a recent letter, dissenting somewhat from my position, says he "has not had a single lung infection following general anesthesia." He attributes it to his technic. But that has not been the fortune of many others. The reports and an analysis of the cases will confirm my findings, however, as to the major conditions stated above. Dr. Barlow, Jackson Clinic, says, "There is a greater tendency to post-operative hemorrhage under local than general anesthetic." That embolism is more frequent is generally reported. These answers also show fatalities more frequent under local than general. This would agree with Dr. Dabney's report. My own observations confirm these. To recapitulate: In pulmonary tuberculosis if a tonsil is to be removed it is evident that that form of anesthetic as well as technic should be employed that produces the least material for aspiration; the least shock; quickest post-operative recovery, with the least incidence of lung complications following it. Clearly then, the general ether anesthesia is the logical one. In a series of cases during the past seven years, I have operated under ether in active and quiescent cases and no unusual after effects were noted. There has been increased nourishment and uninterrupted recovery from the operation. Two cases under local do no better. In fact, I had a rather unfavorable reaction in both in comparison. Dr. Mitchell, of South Bend, Indiana, reports one hundred ether anesthesia to pulmonary tubercular patients with no untoward results. If the incidence of pulmonary tuberculosis is as great or even one-half as great among children as we are creditably informed, then all of us have operated on many cases of quiescent pulmonary tuberculosis without noting it.

CONCLUSIONS

1. There is definite indication in pulmonary tuberculosis, both active and quiescent, for removal of infected tonsils; as also is the indication for removal of focal infection elsewhere. I have reported benefits from removing nasal obstructions in tuberculosis. Manifestly, uninfected tonsils should not be removed.
2. Far advanced tuberculosis cases are not subjects for operation.
3. The La Force clamp enucleating operation gives the best results since it conforms nearest to an ideal tonsillectomy.
4. The personal element is the determining factor of the equation in this as well as in all other operations.
5. In my experience as well as in the experience of many others general anesthesia by inhalation is preferable and thought to be safer.
6. No anesthetic and no operation is without danger nor will they ever be fool-proof.

THE MARATHON DANCE

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Having just completed the unique experience of being the physician in charge of a so-called "marathon dance" at Hammond, Indiana, my observations of the same may be of interest to the medical profession and also to the laity.

This contest extended over a period of one thousand two hundred fifty-two hours, exceeding all previous records by two hundred seventy hours. According to the rules of the contest each hour consisted of forty minutes dancing, and twenty minutes consumed in eating, bathing and receiving attention from their trainers. Contestants were removed from the floor in hospital carts and usually were asleep before they reached their training quarters only a few feet away.

Before the contest started, I examined fifty-one couples ranging in age from seventeen to thirty-five years. Of this number three men were rejected, due to urethral discharges, and one woman, due to mitral insufficiency.

During the first ten days the dance hall was a bedlam of sore feet, blisters, callouses, corns, etc. During this time practically every contestant developed blepharitis to some degree. It is my belief that many contestants had to discontinue dancing due to the ignorant, mauling massages administered by their inefficient trainers. After the first day or two it became apparent that this was a contest where mind ruled body rather than vice versa, as one would presume.

It was observed during this period and even throughout the remainder of the contest, that the first physical break noticed in a contestant was a change in mental state; either becoming hilarious, depressed, or irritable, the greater number falling in the last classification. The individual would complain of some objectionable mannerism of his or her partner or of the audience. Clouding of consciousness, disorientation, delusions, acute confusion and multiform hallucinations were the symptoms presented. One young widow after ten days developed an exhaustion psychosis and was removed from the contest. She at times was hilarious, saying she never felt better in her life, then would suddenly burst into a fit of crying maintaining she was being held in a house of prostitution and would whisper suggestive methods of escape. This individual did not recover completely for two weeks. However, as soon as a mental state was noted the contestant was disqualified and the psychosis, as a whole, cleared up after a few hours rest.

Another striking observation was the inhibition of inhibitions similar to that produced by alcohol, resulting in careless exposure, showing an entire lack of modesty.

After nine hundred hours one female contestant developed a slight pulmonary hemorrhage and was immediately disqualified and sent to the hospital. Later it was learned that she had had a previous hemorrhage three months before. This case made an immediate recovery so far as the acute symptom was concerned, but has pulmonary tuberculosis and is changing climate under advice of her physician.

Throughout the entire contest, over a period of seven weeks, there was an almost universal fall in blood pressure, with varying acceleration and retardation in pulse rate. Invariably during sleep the blood pressure was an average of 5 m. m. lower than during waking hours. Regular examination of urine specimens showed occasional albumin and sugar but only for a day or so.

The worst hours for the contestants usually came in early morning lasting until noon. I believe a great deal of this was psychological, the crowd having gone, the music stopped, and the glamour ceased, promoted the depression.

CONCLUSIONS:

1. I do not believe that the exhaustion psychosis will result in definite impairment of the brain as the result of such a contest.
2. I believe that without a doubt, the prolonged insult to all the tissues, due to an accumulation of the waste products, cannot help doing definite harm.
3. Many foot troubles are certain to be permanent.
4. Enlarged veins of the legs due to venous stasis will result in varicosities.
5. Contrary to the popular lay opinion I do not believe that there results any definite cardiac pathology other than the result produced by the prolonged insult of the accumulation of waste products.

6. The deleterious effect seems to be solely one of loss of sleep.

7. Preventative measures should stop such contests as no one but the promoter is benefitted.

PREGNANCY WITH COMPLICATIONS

(CASE REPORT)

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Case No. 1. Mrs. G. R., 37, married, gravida seven, para five, measurements small. The patient lived in poor surroundings and was very hard worked. No clear history could be obtained as she spoke no English. Physical examination showed a five-months pregnancy with profuse hemorrhage and soft friable cervix partially dilated (two fingers) through which the placenta could be felt. The progress of the case resulted in profound hemorrhage with treatment for shock. She was packed at home and delivery of the child occurred in the ambulance en route to the hospital. The patient was treated for hemorrhage and recovered without further trouble.

Case No. 2. Mrs. C. G., married, twenty-five, good pelvic measurements, gravida one. Her history was that of a patient who had always had good health. Retroversion of the uterus, second degree, was found on pelvic examination early in the first trimester. The patient had breech presentation, and mass low in the pelvis which was found to be the placenta. This was located at the edge of the cervix when dilatation had become complete. There had been no bleeding during gestation, and parturition presented extreme difficulty in delivering the child's head over this placenta. Forceps were applied to the after-coming head and a white baby was delivered with great force, tearing the perineum in addition to the episiotomy. The child resuscitated after a half hour's hard work.

Liebermann gives an occurrence of one in one hundred pregnancies while Polak states that one case in one thousand pregnancies will be placenta praevia. These two cases are drawn from a study of two hundred twenty-five consecutive pregnancies.

The causes of placenta praevia are somewhat clouded. Endometritis, multiparity (it is four to six times as common in multiparae as in primiparae), closely repeated pregnancies, recurrent infections, tardy fixations, abnormally low tubal orifice are chief among the many etiologic factors mentioned.

The implantation of the placenta may be central (completely covering the os), marginal (with the edge of the placenta at the os) or lateral, in which instance, the placenta presents at complete dilatation.

Bleeding is the most constant clinical finding; this may occur as early as the third month but most often appears during the seventh or eighth months. The bleeding is most marked after the contraction passes if pain is present. Abnormal presentations are common in this condition. By making a careful, aseptic, vaginal examination, one may feel the placenta attached over or near the os. If the cervix is contracted (not dilated) and the muscle firm, the diagnosis of placenta praevia is not likely to be substantiated as that makes the cervix friable and patent. Placenta preavia must be differentiated from abruptio placentae. The presence of enlargement of the uterus is most helpful in making this differentiation.

With careful handling mortality may be kept to ten per cent for the mothers. The mortality of the babies is high because of asphyxia, maternal hemorrhage, prematurity and operative manipulation.

Version with breech extraction is the treatment of choice in the large majority of cases. Manual dilatation is dangerous and in cases where dilating is necessary, the introducing of a bag is perhaps wiser. Cesarian section is rapid, effective and has slight loss of blood; this is probably best performed in primiparae with central placenta praevia or in multiparae at seven to nine months with two or three fingers dilatation, in poor condition from loss of blood. In other cases of the central form, one might have to work around or through the placenta. Haste and violence are to be avoided. Shock, hemorrhage and sepsis are the usual causes of death. Treat the loss of blood by elevating and bandaging the limbs, heat, morphine, fluids, contraction of the uterus. With a viable child, follow the fetal heart beat carefully. Sepsis is reduced by careful aseptic vaginal preparation.

DIET AND THEOPHYLLINE IN TREATMENT OF CARDIAC FAILURE

Further observations made by Fred M. Smith, Iowa City (*Journal A. M. A.*, Oct. 27, 1928), on a largely milk and carbohydrate diet previously reported have emphasized the importance of this feature in the treatment of cardiac failure. A greater significance is attributed to the carbohydrates and particularly the sugars of the diet. It is also suggested that the beneficial action of carbohydrates on the liver injury induced by prolonged congestive failure may contribute to the effectiveness of the diet. Intravenous administration of dextrose solution is not advocated if the patient is able to take food by mouth. It is felt that the diet is a more effective means of providing sugars. Theophylline is a valuable measure in the treatment of the cardiac failure of arteriosclerosis. The best results are obtained in the congestive type of failure. Experimental and clinical observations support the belief that the elimination of fluid is promoted by the favorable influence on the coronary circulation. Theophylline in doses of 2 or 3 grains (0.13 or 0.2 Gm.) after meals has repeatedly been administered throughout the period of hospitalization and in some instances was continued after the patient returned home. There have been very few complaints of abdominal discomfort which could be attributed to the drug.

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EDITORIALS

ANESTHESIA IN TONSILLECTOMY

At the St. Louis session of the American Academy of Ophthalmology and Otolaryngology, October 15 to 19, 1928, an interesting paper (Bronchoscopic Study of Aspiration in Tonsillectomy, by Louis and Ray K. Daily) was presented, in which the appearance of lung abcess following tonsillectomy was discussed, and in which the anesesthesia risk was considered.

Attention was called to the divergence of views concerning the occurrence of post-tonsillectomy lung abscess, some observers maintaining that the abscess is caused by infected emboli from the peritonsillar tissues, whereas others believe that the abscess is due to direct aspiration of infective material during the operation. One authority was quoted as arguing against the aspiration theory because the majority of lung abscesses are located in the upper lobes of the lung and that only the embolic theory can explain the occurrence of lung abscess when the tonsillectomy is done under local anesthesia. On the other hand, authorities were quoted who favor the aspiration theory for the reason that embolic abscesses usually are pyemic in their course and post-tonsillectomy abscesses are chronic. Experiments concerning these views were cited, including the experimental pulmonary lung abscess produced in twenty percent of mice, guinea pigs and rabbits by introducing intra-tracheally the infectious material obtained from the teeth of persons suffering with pyorrhea.

To all of this the authors add their bronchoscopic and esophagoscopic observations of one hundred cases of tonsillectomy under general anesthesia, and six cases under local anesthesia. The authors state that the outstanding phenomena of their investigations were the presence of blood in the lung and its absence in the stomach, or vice-versa, and the fact that it depended almost entirely on the depth of anesthesia. Their findings seemed to prove fallacious the oft-repeated statement seen in the literature urging as a prophylactic measure against aspiration in tonsillectomy an anesthesia abolishing the pharyngeal reflexes. Their investigations convince them that the very lightest anesthesia which will permit of an operation is the anesthesia of choice to avoid aspiration of blood and infective material into the lungs. If post-tonsillectomy lung abscess is of aspiratory origin the offending agent is probably the bacteria laden material squeezed from the tonsil with the grasping forceps or tightening snare.

Conclusions based upon the hundred cases they carefully observed, are that aspiration of blood occurs in ninety percent of tonsillectomies performed under deep anesthesia, and that aspiration can be avoided by operating with the swallowing reflex not abolished. They also claim that their observations and experiments indicate that the lung eliminates the aspirated blood by peristaltic waves, assisted probably by the action of ciliated epithelium and cough, and that the location of post-tonsillectomy abscesses points to aspiration as their cause.

In addition to light anesthesia with the swallowing reflex not abolished we would like to add the advantage of operating with the patient lying on the left side, the head slightly lower than the hips, a position which at no time offers a field obstructed by blood or secretion which by gravity run toward the mouth, requires no suction apparatus, and adds to the lessened tendency to aspiration even if through accident or otherwise the anesthesia gets to the point where the swallowing reflexes are abolished. We are strongly of the belief that post-tonsillectomy lung abscesses are caused by aspiration of blood or infective material, and that they may be almost if not wholly prevented if the anesthesia is not deep enough to abolish the swallowing function, and the patient is operated lying in the position described. This opinion is based upon several thousand cases, operated in several clinics where the practice is followed and without a single case of post-tonsillectomy lung abscess.

STERILIZATION OF DEFECTIVES

We note that the November number of *The American Mercury* has an article on "Social Hygiene", by Maynard Shipley, in which the sterilization of defectives is discussed, and attention called to the experience in California which continues to be the great national testing ground of the eugenic and therapeutic sterilization of the insane and imbeciles. It is pointed out that sterilization is a dangerous power to put in the hands of any body, particularly one made up of politicians. Therefore it must be safeguarded. Nevertheless, the tendency of defectives is to mate with defectives, and the net result is some twenty percent of defectives in the American population. Utopia, of course, would not be brought about even if every imbecile in the United States were sterilized tomorrow, for too many apparently normal persons are carrying recessive strains of feeble-mindedness for one thing, but certainly no

good is being accomplished by perpetuating markedly imbecilic strains. It is well known that in such tainted families even those who escape imbecility show an unduly high average of epilepsy and insanity.

The total number of persons liable to sterilization under the law in California runs to tens of thousands. It is estimated that there are considerably more than 20,000 of the feeble-minded in the state. By far the greater number of them are not in the over-crowded state institutions, which have room for only those from broken homes or without means of support, but are mixed with the general population, busily engaged in reproducing their kind. Authorities state that while there are 50,000 feeble-minded persons in the institutions of the country, there would be at least 500,000 if the institutions were large enough to care for all who are eligible to enter them.

The sterilization operation performed by California and other states having sterilization laws is not castration. It does not in any way interfere with the sexual lives of the patients except to make them incapable of procreation. The males undergo vasectomy, and the females undergo salpingectomy. Neither operation is dangerous, and the patient suffers no pain. No one may be legally sterilized in California on the unsupported judgment of any one official, even though the sterilization is compulsory under the law. The medical superintendent's judgment must be ratified by the director of the State Department of Institutions, and also by the director of the State Department of Public Health. Even so, in actual practice, few operations have been performed without the written consent of the nearest relatives, when any such were to be found.

In California the results seem to show that though such a measure can be only partial in its effects on mental deficiency and abnormality, in the population as a whole it is a valuable therapeutic and eugenic agent. Continued long enough and properly applied it cannot fail to lower the incidence of inherited psychoses.

STATE MEDICAL AID AND ITS ABUSES

In several previous issues of THE JOURNAL we have commented on the abuse of free service furnished by the state laboratories, and criticized the state Board of Health for permitting certain abuses to creep in even if abuses are not encouraged. We do not doubt for a moment that some of the abuses can be checked by the secretary if he puts himself to the task. It has been charged that he has been encouraging a good deal of free and undeserved service for reasons that may be interpreted as a desire to further the cause of state medicine and incidentally popularize himself with the public. Similarly the University hospitals in Indianapolis, including the Long Hospital, the Riley Hospital for Children, and the Coleman Hospital for Women, have been charged with accepting as indigent patients some persons amply able to pay, thus encouraging pauperism, dependency, and unnecessarily increasing the taxation of the people for the support of such unworthy persons.

In analyzing this question we are forced to admit that most of the abuses of the state laboratories and the university hospitals can be traced directly to encouragement and aid from members of the medical profession. In the case of the state laboratories probably two-thirds of the work done there in the way of examining specimens is work that could and should be paid for by the individuals but is sent to the laboratories by physicians who know that there will be no charge for the service. Not infrequently, as proof has shown, a grasping and dishonest physician has charged his patients for the service rendered gratuitously by the state laboratory. In like manner proof is obtainable to the effect that through the connivance of physicians, township trustees, or judges, patients have been committed to the three university hospitals as indigent patients when, as a matter of fact, the patients were amply able to pay the full or at least part fees for the services rendered. If specimens from well-to-do patients are sent to the state laboratories for free examination, and with the statement that the patient from whom the specimen is taken is indigent, and if well-to-do patients are certified to university hospitals as being indigent, does the fault lie with the state laboratory or the university hospitals, or does it lie with physicians whose signature must be appended to documents presented in the instances mentioned?

Isn't it time for a little inventory of our own remissions in our duty as medical men in connection with this subject of the abuse of state medical aid? As a matter of fact there is a growing tendency on the part of a large proportion of our population to try to get something for nothing in the way of aid in the promotion or preservation of health, and altogether too often medical men are promoting this tendency, as is the case when they misrepresent conditions in committing patients to the university hospitals, and when they send what should be pay specimens to the state laboratory for free service. That they are digging their own graves does not seem to occur to them. They decry paternalistic or state medicine and yet they are helping to promote it.

A unified profession must solve this question of the abuse of medical charity by cleaning its own house of the false position it now occupies. Neither individual physicians nor individual laymen should take advantage of the free service of the state laboratories when they can and should pay for such service. What is true of the service

of the state laboratories is true of the service rendered by the university hospitals. The university authorities have neither the facilities nor the inclination to investigate the truth or falsity of the committment papers of patients when signed by a physician, a trustee, or a judge, and if a physician is honest with himself and with his patient there will be no abuse of the services rendered by the University hospitals.

This brings up another question and that is the need and the demand in practically every county in the state for medical and surgical services for not only the indigent but for a still larger class of patients who are able to pay something though unable to pay the customary fees. It is the latter class of patients who so often are shunted into the free clinics and are willing to be sent there if they know that they are to receive competent service free of charge. The organized medical profession in any community should arrange to take care of that class of patients, and if it does not do so, lay enterprise will attempt to do it, and to the detriment of the medical profession and public alike as would be expected under such conditions. Our suggestion is that every county medical society should maintain a clinic, or something analagous to a clinic, the details concerning operation of which can be worked out, for the proper care of not only the indigent but that class of people who are unable to pay the regular fees but who can pay something and who are entitled to good service. It may be argued that the individual physicians at present are caring for such people and at fees consistent with ability to pay, but in reality there is no system in this, and no uniformity in the matter of charges or the kind of service to be rendered. With the existence of one or more hospitals in almost every county of the state, it is possible for the medical profession as included in the various county medical societies, to organize a clinic, with hours on certain days, and perhaps divided between different hospitals where service of every kind can be rendered to the moderately poor at fees within their means, thorough investigation having been made as to the worthiness of the case before admittance to the clinic. Even the hospitals, assisted by funds from the community chests, should be willing to join in making the plan a success. Certainly the medical profession, individually and collectively, must at an early date take a definite stand on this question of correcting the abuses of medical charity and in aiding the moderately poor in securing adequate and competent service for compensation within their means.

MALINGERING

A five-year-old New York boy, drilled to pretend he was mute, and who resisted the efforts of seven specialists to make him talk, finally yielded to anger and talked, exploding the dreams of a mother who was trying to secure a fifty-thousand dollar verdict for injuries that she alleged had destroyed the boy's voice. Even the judge of the court, after forty-five minutes' trial, failed to make the boy talk, but a court attendant did the trick by suddenly asking the boy about an injustice that had been practiced upon him by pinching to make him talk. No matter how much he is schooled it is difficult to make the child play the part of a malingerer for any length of time. An adult may play the game successfully, and there are any number of instances on record where a malingerer successfully has evaded discovery even after the keen observation and critical examination of experts. A case is on record in Indiana where a man received a railroad injury that supposedly produced a motor paralysis of the lower extremities, and for more than two years he was in a wheel-chair and in every way was assisted as a paralytic, not once "slipping up" in his deception either in the hospital or in his own home. Capable surgeons testified that the man had a permanent paralysis of the lower extremities, and equally as capable surgeons testified that they thought he was a malingerer though they were unable to prove it. The jury decided that he was a paralytic, and awarded $25,000 damages. Upon receipt of the check the paralytic soon threw away his crutches, smashed his wheel chair, and announced to his friends that the $25,000 was worth the two years of inconvenience and vigilance put forth to prove that he was deserving of the judgment rendered.

Every physician of considerable experience has met with malingerers. In fact he has to be on his guard to detect malingering. However, there is another type of alleged disability that may be mistaken for malingering or for an incurable pathology, and that is hysteria. It is such cases that form the basis of the marvelous cures brought about by emotional disturbance or some bizarre form of treatment that carries with it the right form of mental stimulant. Hysterical joints, hysterical loss of voice, or hysterical loss of vision in one or both eyes are examples. Intelligent and well-trained physicians are curing such cases all the time and think nothing of it, but if perchance one of such cases falls into the hands of any one of the quack miracle healers and a cure is accomplished the newspapers publish the facts with suitable embellishment and the public gets the idea that whatever has accomplished the result in the hysteric will cure everything from consumption to corns on the big toe. Verily, the physician must be on his guard, and at all times exercise the keenest judgment to differentiate between real and imaginary

diseases, and he ought to be able to treat both intelligently and effectively.

SUGGESTIONS FOR EVANSVILLE SESSION

The State Medical Association officers, including officers of sections and the councilors, will meet in Indianapolis at an early date to discuss program plans for the Evansville session. We shall offer some suggestions that we have heard from various sources, and they are as follows:

Arrange for short scientific meetings, and avoid theoretical discussions and papers "over the heads" of most of the audience.

Aim to give those in attendance something that they can take home with them for use in their every day work. Practical papers and demonstrations in medical, surgical or laboratory technique, or the latest progress in diagnostic or therapeutic aids always enlist the interest of all.

Refuse a place on the program to the man known to have no regard for the time or patience of his audience, and who talks along ramblingly without much point to his discussion.

The program committee must be cold-blooded and refuse a place on the program to the man who is trying to exploit himself.

Reserve a place for the discussion of economic subjects which are very pertinent at the present time, and preventive medicine—the medicine of the future.

Especially should attention be given to the current progress of medicine and surgery.

Hold every essayist and discussant to the time limit established.

Do not have more than two, or at the most three men from outside of the state on the program. We have plenty of good material at home and *don't forget the young men.*

As an aid to the program committee we suggest that county medical society secretaries ask their members what kind of program or entertainment they would like to have at Evansville, and then notify the executive offices in Indianapolis concerning the wishes expressed.

Don't forget that the "glad hand" is not only acceptable but necessary for a successful session. Talk to any old-timer and he will refer to the sessions at which he had the best time socially and took home with him the most practical ideas for every day use.

Our aim should be to have our annual sessions such that they will be looked forward to with anticipation, and afterward reflected upon with favorable remembrance.

THE SORDID SIDE OF THE PRACTICE OF MEDICINE

We know that there are many physicians who look to the financial gain from the practice of medicine as the principal objective. Some of them exaggerate the dangers of commonplace affections in order to secure increased compensation for service; others recommend and perform unnecessary operations; and still others, through the disreputable fee-dividing practice, sell their patients to the highest bidder—all of which is the sordid side of the practice of medicine. On the other hand, thanks to a conscience that is unwavering in its fidelity to honesty and the highest traditions of the medical profession, there are physicians who devote their time, talents and occasionally even their money, with no thought for monetary reward except that which is fair and just, and often with no other thought than the personal satisfaction of giving service to suffering humanity. However, the laborer should be paid, for it is his right, but the service for which compensation is given should be honest and faithful service, and no laborer is more worthy of compensation for honest and faithful service than is the physician.

The complaint registered against the average physician is that he does not take advantage of the opportunity offered for adequate and just compensation for competent and faithful service. This is evidenced by the insufficient charges made for services of a highly skilled and technical nature, rendered to patients not only able but willing to pay just fees. It also is evidenced by neglect on the part of so many physicians who fail in their real duty to their patrons in practicing preventive medicine, the real medicine of the future. For instance, how many physicians are urging their regular patrons to have health examinations, so highly advisable for every person, and for which a respectable fee may be charged? How many physicians are urging and practicing vaccination as a prevention against diphtheria, scarlet fever, typhoid, and smallpox? In fact, how many physicians actually are trying in a sincere and intelligent way to keep their patrons well and charge them for the service? We do not for one moment believe that the economic side of the practice of medicine should be the only thing considered, but as it is necessary for us to obtain an income from our work, in order that we as well as our families may live and enjoy some of the comforts and luxuries that others have, why not exhibit a little of that enterprise that gets business in other vocations of life? Why not render the service that really is indicated and necessary as preventive health measures for our patients, and secure the just and reasonable compensation for it that we deserve?

AN ARBITRARY DENTAL BOARD

We wonder that the prominent dentists of the state do not rebel against the unjust exactions placed upon them by the Dental Board of Registration and Examination through an unfair, inconsistent and probably unconstitutional inter-

pretation of the dental law governing the employment of unregistered assistants. As it stands now, according to information received from some of our dentist friends, no dentist is permitted to have an assistant who does any dental work for the patient. It is reported that one reputable and highly ethical dentist who employed a well-trained woman to do some of the less exacting detail dental work for patients was swooped down upon by the Board of Dental Registration and Examination and told that if he continued to employ the woman in question he would be considered as unprofessional and the assistant would be prosecuted for practicing dentistry without a license to do so. Certainly the Board has the dentists brow-beaten into meek submission, for we will bet ten dollars to a punched nickel that legally they can not enforce their mandate. We do not believe there is any court, and certainly no jury of laymen, that would uphold such an arbitrary stand, which is not only inconsistent and unnecessary, but in many respects a detriment to dentists and public alike.

When you come right down to brass tacks a patient goes to a dentist's office expecting to have adequate and trustworthy service at his hands, *and he alone is held responsible for it.* No reasonable and sensible patient objects to having the detail work done by an assistant, whether the assistant is licensed to practice dentistry or not, as long as the work is done under the supervision of the dentist consulted who in the final analysis is the one who both morally and legally is held responsible for work that is done, no matter by whom it is done so long as it is performed in his office. In reality, the arbitrary interpretation and enforcement of the law by the dental board works a great injustice to every competent and highly ethical dentist who is compelled to do *all* of the dental work for his patients, including even the most superficial mechanical service that could well be done by an assistant. In consequence there is a tendency either to neglect or to refuse to do some of the simple things in the way of preventive treatment, like cleaning the teeth for instance, because it takes time and because it does not require sufficient skill or experienc to justify an adequate charge for the time consumed. There was a time when the medical board of this state, tiring of their unsuccessful efforts to check the practice of many unlicensed physicians, attempted to persecute some of the reputable physicians of the state because they employed, on salary and under their personal direction, unlicensed assistants. It failed of its purpose, for the Board was defeated at every turn, and, if our memory serves us right, in one instance a notorious advertising quack defeated the Board in efforts to prevent the quack from employing unlicensed assistants. A cold-blooded lay jury will not stand for any high-brow impositions like those enforced by the Dental Board, and particularly when the exactions are not in the interest of either the public or the dental profession. It is one thing for a board to make an arbitrary interpretation of a law and quite another thing to make the interpretation stick when it comes into a court of law.

EDITORIAL NOTES

DEAR DOCTOR:

THE JOURNAL and the Cooperative Medical Advertising Bureau of Chicago maintain a Service Department to answer inquiries from you about pharmaceuticals, surgical instruments and other manufactured products, such as soaps, clothing, automobiles, etc., which you may need in your home, office, sanitarium or hospital.

We invite and urge you to use this Service.

It is absolutely *free* to you.

The Cooperative Bureau is equipped with catalogues and price lists of manufacturers, and can supply you information by return mail.

Perhaps you want a certain kind of instrument which is not advertised in THE JOURNAL, and do not know where to secure it; or do not know where to obtain some automobile supplies you need. This Service Bureau will give you the information.

Whenever possible, the goods will be advertised in our pages; but if they are not, we urge you to ask THE JOURNAL about them, or write direct to the Cooperative Medical Advertising Bureau, 535 N. Dearborn St., Chicago, Illinois.

We want THE JOURNAL to serve *you.*

PAY YOUR DUES NOW.

THE season's greetings to every reader of THE JOURNAL. We wish you a Merry Christmas and a Happy New Year.

THIS number of THE JOURNAL contains the index for the year. It will be found useful to those who bind their journals.

FAILURE to pay dues on time cost one Indiana physician more than a thousand dollars, because he had to pay his own expenses in a malpractice suit rather than have the Association pay them. It is better to be safe than sorry.

Is it economy or an attempt at artistic effects that prompts the metropolitan theaters to compel their patrons to read programs by the dim light afforded before the curtain goes up as well as between acts? This is another one of our "pet peeves".

THE preservation of medical ethics is necessary for the maintenance of the standing and respect of the profession, and is best for the protection of the public. When we lower medical ethics we also lower the respect which the public has for the profession.

MEDICAL men on hospital staffs who are guilty of commercialism, bungling surgery, or the performance of unnecessary operations should be ruled off the staffs, according to the opinion expressed by a member of the Council on Medical Education and Hospitals of the American Medical Association. What a pity that such a rule is not more often in force!

THE Rockefeller Foundation complains because physicians give too little attention to periodic examinations and advice about personal hygiene in order to keep people well. The complaint is well founded. We are altogether too anxious to devote our time and attention to the cure of disease rather than its prevention, and yet preventive medicine is the medicine of the future!

IT is a recognized fact that the medical man who does not attend county, state or national medical society meetings is the one who really needs the benefit to be derived from attendance at such meetings. One of the problems of medical society secretaries is to get the weak members of the fraternity in his community to recognize the benefit that comes through attendance at medical meetings.

FORTUNATELY we have few county medical societies in Indiana that meet only once a year to elect officers for the purpose of maintaining affiliation with the Indiana State Medical Association, but there are one or two such organizations, and our councilors should make some effort to change those societies into active working organizations. Clinical meetings, with discussion of case reports, form the best programs for small societies.

IN approving diagnostic laboratories the A. M. A. shows commendable judgment in recommending that x-ray plates should be interpreted by physicians who have been trained for the work rather than by technicians who have not graduated in medicine. In New York state, non-medical technicians, who attempt to interpret x-ray plates are considered as practicing medicine, and therefore may be prosecuted for practicing medicine without a license.

SOME of the larger county medical societies do not have the attendance at meetings that they should have, and sometimes the poor attendance is influenced by the multiplicity of societies and hospital organizations which schedule frequent meetings. A good suggestion recently has been made, that county medical societies can with profit combine their meetings with meetings of hospital staffs, with perhaps the program turned over to the hospital staff.

THE Missouri State Medical Association has adopted a resolution concerning the unreliability and worthlessness of expert testimony both by the state and by the defense in criminal cases in which insanity is the plea. It is recommended that an amendment to the by-laws be adopted whereby any member violating the act concerning expert testimony be amenable to the board of censors of his society for unethical conduct. The report of the committee was adopted.

PERIODIC health examinations are neglected by the average physician, and in many instances when done are too superficial. To the physician who always is looking for profit we may say that periodical health examinations are a source of revenue not to be despised, but aside from that the physician owes it to himself and to his patrons to advocate such examinations in the interest of health preservation, and to make such examinations thorough and trustworthy.

The Hahnemannian Monthly for August, discussing the subject of doctors as letter writers, says that the doctor who is tardy with his correspondence is paving the way to be cast into the professional junk heap. A new generation is arising that is all activity, initiative and business. Their motto is "Do it now". Needless to say, these young men are crowding the procrastinators out, for as active and as busy as they are they always have plenty of time for other things.

PLEASE do not speak of the "Indiana State Medical Society." The official and incorporated name is the "Indiana State Medical *Association.*" Do not speak of our annual sessions as "meetings" —we have meetings at the session. At next year's session, to be known officially as the Evansville Session, we will have *meetings* of the various component sections of the Association, like the House of Delegates, Council, and Sections, the sum total of which for the three days make up the *session.*

ON the suggestion of several prominent physicians we are carrying in the advertising section a directory of Indiana physicians who have been certified by the American College of Surgeons, American College of Physicians, the American Board for Ophthalmic Examinations, and the American Board for Otolaryngologic Examinations. This is a new feature and if there are any suggestions, corrections or additions to be made, please write THE JOURNAL concerning the matter.

THE Indiana University School of Medicine is giving postgraduate programs before those county and district medical societies that ask for the same. The societies may even suggest the type of postgraduate program desired and the University will attempt to carry out the wishes expressed. Applications may be made to the dean of the medical department of the university, at Indianapolis, or may be placed with the executive secretary of the Indiana State Medical Association who will make the necessary arrangements.

AGAIN we desire to say that the columns of THE JOURNAL are open for the publication of the pro-

ceedings of any county medical society, and we respectfully ask the secretaries to furnish the reports. We also desire news notes and personals, interesting case reports, and constructive criticism for our correspondence department. In other words we desire to furnish something of interest to every medical man in the state, whether he is a highly trained professor in the university or a raw recruit in a country hamlet.

The fellow who thinks he is being "gypped" when he pays seventy-five cents for a hair cut during convention time doesn't seem to mind paying theater ticket brokers $10 to $15 for an ordinary $4.40 ticket to a musical show in New York City or Chicago. Evidently it makes a difference whether you are buying amusement or buying a necessity when a howl goes up concerning being "gypped". It does seem as though there should be some effectual way of putting a stop to the hold-up games practiced upon transients in any city.

Hospital conferences are supposed to be for the discussion of work done in the hospital, with the object in view of bettering the service. This would mean a frank discussion of the mistakes made by members of the staff, but how often does a physician admit before his confreres that he has made a mistake, and yet no person in any vocation is free from mistakes and there is no reason why a physician should be ashamed to admit that he sometimes makes mistakes, for it is through our own mistakes and the mistakes of others that we profit.

We are amused when we think of the solicitous interest that a few women take in suppressing suggestive films in moving picture houses but they don't say a word about the indecent leg shows given in every populous community of the country. Some of the uplift women ought to organize a society for the suppression of cruelty to men and put an end to the morally rotten burlesque shows that are given in several Indiana cities. The portrayal of the nude figure on the screen is tame in comparison to the actual nude or near-nude figure and the dialogue that goes with it on the stage.

According to the *Journal of the A. M. A.* New Zealand is wrestling with a bill to prevent through sterilization the propagation of defectives. The bill has met with considerable opposition, even from leading psychiatrists one of whom points out that mentally defective persons are not necessarily the progeny of mental defectives; that in the severer grades mental defectives are deprived by nature of the ability of procreation, and that enormous numbers of mental defectives of all kinds are procreated by apparently normal and healthy persons. He, therefore, asks that the bill be defeated.

The 1928 session of the A. M. A. will be held in Portland, Oregon, July 8 to 12, 1929. At that time the usual summer excursion railroad rates will be in force, and as they are somewhat lower than the usual convention rates it will not be necessary to purchase tickets on the certificate plan or go through some of the other red tape usually necessary in order to secure reduced rates. No doubt there will be a large attendance, for there is much in the midwest and on the Pacific coast to attract midsummer travelers belonging to the medical profession, though of course the annual session of the A. M. A. will be the great drawing card for 1929.

An attempt is being made to perpetuate the Sheppard-Towner Act by the introduction in Congress of a bill that is even more radical and far-reaching in its effects than the original Sheppard-Towner Act. It is not necessary to dwell upon the bad features of the bill, inasmuch as it goes the Sheppard-Towner Act one better in mischief making, and physicians in general are opposed to it. What is needed now is a vigorous protest to congressmen from every thinking physician in the United States. Incidentally, the members of the Woman's Auxiliary can do much to influence our representatives in Congress to vote against any more Sheppard-Towner stuff.

Three representatives of the New York State Medical Society attended the secretaries' and editors' conference in Chicago last month. They had no difficulty in discovering what the sentiment is among a large number of the editors and secretaries of state medical societies concerning the policy of the *New York State Journal of Medicine* in carrying advertising that does not come up to the standards recognized as ethical and proper for those medical journals that are making an effort to maintain a high professional standing. We believe that a majority of the reputable physicians belonging to the New York State Medical Society are ashamed of the advertising policy of their journal.

It is not uncommon, when a physician enters suit to collect from a "dead-beat", that the D. B. retaliates by entering against the doctor a suit for malpractice—and then offering to compromise by dismissing both suits. He thus escapes paying the bill justly due to the physician.

This sort of thing can be avoided by looking up the *statute of limitations*. It varies in different states, but a *longer* time is *always* allowed for the collection of a debt than for entering an action for malpractice.

Do not take the "dead-beat" to court until the time allowed for him to bring a malpractice suit has expired. *Then go after him!—Clinical Medicine and Surgery,* November, 1928.

INFLUENZA is raging in epidemic form on the Pacific coast. The disease, while not of a particularly virulent type, has caused hundreds of deaths in Los Angeles alone. It is hoped that the epidemic will be confined to the Pacific coast, though there is much to indicate that the disease is traveling eastward and already Indiana has many cases of it. Physicians will be wise if they advise patrons to use all the preventive measures known, including in particular the avoidance of crowds, over-heated and illy-ventilated rooms, and the employment of proper dietary and hygienic regulations. Incidentally, vaccination against influenza is reported by many experienced and keen observers as being very efficacious.

WE used to think that patients coming into the office smelling of garlic were enough to test the patience of any law-abiding physician who doesn't want to be arrested for murder, but of late years we have changed our mind and have come to the conclusion that the many patients who smell of home brew are worse pests than those who smell of garlic. We do not remember that in pre-prohibition days the beer smell could be compared to the home-brew smell, and nowadays it seems that a goodly percentage of our male and female citizens are guilty of the home-brew habit. Perhaps we can do something for temperance by telling our home-brew imbibing patients how perfectly rotten their breaths are and that home-brew must be cut out of the dietary.

A few weeks ago the *Chicago Tribune* carried a conspicuous notice to the effect that in order to train its nurses in the niceties of social intercourse, the advantages of a well-modulated and pleasant voice, poise and cultivated manner, St. Luke's Hospital, New York, had established a "charm school" where under the tutelage of a social director the young ladies are to be taught to behave elegantly without giving the matter a thought.—(*Clinical Medicine and Surgery,* August, 1928). Well, well, isn't that nice! But who is going to nurse the patient? Probably these "drawing room" nurses will have assistants to do the real work, and the "drawing room" nurse will be a companion for the sick person. Well, it comes high but there are those who must have it.

THE United States Public Health Service is urging inoculation against typhoid fever, and in order to play safe the inoculation should be at least once in every three years. Unfortunately there are some doctors who seem to think that one inoculation carries with it immunity for an indefinite length of time. As a matter of fact typhoid inoculation once in two years is not too often for those who travel much, and the slight inconvenience or discomfort occasioned by the inoculation is scarcely worth mentioning. An advantageous time for the injection is about four P. M. so that if a reaction occurs it will be while the patient is in bed. Three injections, a week apart, are necessary, and for those employed in business successive Saturdays are convenient.

WE are strongly of the opinion that our Association should have a paid representative on the ground continuously throughout the coming session of the Indiana legislature, and this representative should be in addition to any officers or members of our Association who likewise are watching the legislature for movements that may be either beneficial or antagonistic to the aims and objects of medical men. The point is that we should not only have someone on guard to protect our interests but to further our claims for recognition in those matters that pertain to medical practice, education, or the promotion of public health. Other states have their paid representatives, why should not Indiana? Call it politics if you will—we call it vigilance of a type that is absolutely necessary.

THE medical society that meets only to indulge in salacious stories and ribald jokes reminds us of the church that greets its minister with the song, "For He Is a Jolly Good Fellow", and, encourages more or less suggestive and "interpretative" dancing in the social room. It is a wonder to us that some of the so-called up-to-date churches do not begin their Sunday services by singing, "Hail! Hail! The gang's all here. What the hell do we care now." In our judgment you cannot "jazz up" a medical society any more than you can "jazz up" a church and have it represent its real purpose in life. It isn't necessary to go to a medical society meeting or a church meeting with a long face, but each requires an attitude of seriousness and respect if the most is to be accomplished.

THIS is the month when many county medical societies will re-elect officers for the coming year. We suggest that great care be exercised in the selection of a secretary, for, as often said in these columns, a secretary can either make or break a society. Give the secretaryship to some wide-awake, progressive and genial fellow, and don't forget to give him encouragement and support. It is a good plan to give him a small honorarium, either by way of a commission on dues, or a flat sum for the year's work. A secretary's job is said to be a thankless work, but a secretary may be made to feel that he is appreciated if you give him an honorarium. Under any circumstances,

don't fail to give him your heartiest support in his endeavors to do something in your own interest.

A correspondent of one of the metropolitan dailies complains because ninety-three tourist steamers will leave New York during the first three months of the coming year, all bound for distant shores and crowded to capacity with passengers not a tenth part of whom have seen their own country. It is very evident that inhabitants of the United States are getting to be the greatest travelers on earth, and the reason that they can travel is because they are prosperous. It is a good sign when along with their prosperity they desire to improve health, broaden their views, and increase their spirit of tolerance. The man or woman who goes to Europe, Africa, South America, or the Orient comes back home a better citizen. By all means let us not criticize him, but encourage him to travel if he can afford it.

We have been asked to aid in the establishment of birth control clinics in Indiana. The sum of $500 is required to secure the services of someone to organize the clinic. (Perhaps one of the large rubber companies would be interested.) We are not inclined to respond favorably, for we never have looked upon the birth control movement as being worthy of such widespread adoption as will be made possible through such indiscriminate teaching as is bound to occur if birth control advocates continue to spread their propaganda as widely as desired by them. Furthermore, this birth control instruction is under the domination and control, for the most part, of a lot of lay women, and the matter is of such vital importance to public health and morals that it ought to be dominated by the medical profession if it is to receive intelligent consideration and not be abused.

The Medical Department of the University of Iowa is receiving some very substantial aid in carrying out various plans for improving buildings, equipment, organization, teaching and research. The Rockefeller Foundation skips over Indiana, but perhaps as an excuse it would be said that the Medical Department of Indiana University has not been able to secure as much financial support from the state as it should have had in order to be comparable to the medical departments of many other state universities, and yet notwithstanding the need for more and better equipment, our University Medical School has made an enviable record for itself in the character of graduates turned out. Perhaps if the institution can do a little more research work, and get our incoming legislature to furnish funds for it, we too can get a lift from the Rockefeller Foundation. Let us hope!

We have heard a few complaints concerning the high-brow character of some of the addresses or talks given before county medical societies by outsiders. There is an urgent demand for practical information such as can be used by the average general practitioner in everyday work. The latest information concerning the diagnosis and treatment of disease is welcome, but many men in active practice balk when they are asked to listen for an hour or two to highly scientific and oftentimes theoretical discussions. One very prominent general practitioner tells us that not long ago he listened for an hour and a half to an address on the chemical constituents of certain types of food, and when it was all over he knew just about as much about the subject as he does about Einstein's theory of relativity, which no one understands and which some are unkind enough to think is not understood by Einstein himself!

The evolution theory requires no stronger proof than the action of some legislatures that would prevent the teaching of evolution. The trouble with such monkeys is that they have not developed according to evolutionary laws. We admire the stand of the dean of the Medical Department of the University of Arkansas who says that notwithstanding the recently enacted law in Arkansas forbidding the teaching of evolution in the public schools, the university will go ahead teaching the theory of evolution just as in the past, regardless of the law. Arkansas like Tennessee has been made ridiculous in the eyes of the world as the result of a controversy and finally law-making that is analogous to Volivia's argument and forced teaching that the world is flat rather than round. Well, as we often have heard, it takes all kinds of people to make a world, and there are a lot of peculiar people running loose who ought to have guardians.

That the abuse of clinics is aided by physicians is evidenced by an official report we have received from Michigan in which it is stated that during the year ending June 30, 1928, seventy-four Indiana patients were admitted to the University Hospital at Ann Arbor. Forty-six of these patients were referred by Indiana physicians. Several of the referred patients were amply able to pay a fee in addition to hospital charges, and it is believed that a fair investigation would indicate that many more of the patients received as charity patients were able to pay a fee. This report corresponds to the report which comes from our own University hospitals in Indianapolis and indicates that if we ever are going to break up this abuse of medical aid by our State Institutions some reform must be practiced by the Indiana physicians who are guilty of the practice of referring patients to the free clinics when such

patients are amply able to pay something for the service.

A student's health board has been organized in one of the Chicago suburbs. It seems to have been organized by and has the greatest support of girl students who are attempting to banish high heels on shoes, and to adopt rules requiring good but plain food, regular exercise, plenty of sleep, and the interdiction of smoking and use of alcoholic beverages. It is a good sign when students will take up these reforms, and possibly something tangible will result in consequence. To reduce the present tendency in a good proportion of students to use tobacco and alcoholic beverages regularly, and oftentimes excessively, would in itself be a great advance in the preservation of the health and morals of the rising generation. Mothers, fathers, preachers, teachers, and medical men may preach until the millenium and not accomplish as much in the way of reform as can be accomplished by an organization within the student body, so let us encourage health boards among students.

TRAVELING expenses incurred by medical men in attending meetings of medical associations are deductible in the computation of federal income taxes. This has been brought about as a direct result of the recent decision of the Board of Tax Appeals, and it is interesting to know that refunds may be collected since 1922 when the commissioner of internal revenue first denied to physicians their right to deduct traveling expenses in computing their taxable incomes. In order to secure the refund it will be necessary to produce adequate proof of the exact amount paid for railroad fare, Pullman accommodations, hotel accommodations, meals, and other allowable expenses, and while in some instances this may be difficult owing to lapse of time, yet in other instances it is entirely possible, and particularly so for those physicians who are in the habit of keeping a record of expenses. Applications for refund must be made on the special form provided for that purpose, copies of which may be obtained from the income tax offices.

THE City Health Commissioner of New York City is attempting to weed out the commercial clinical laboratory. He is backed up by a provision in the sanitary code which says that "no person shall conduct a laboratory unless he has a permit from the board of health, has had three or more years of general laboratory training, and has the prescribed degree." The action has become necessary because clinical laboratories have been run on a production basis, and the work has been done by persons who have insufficient training and experience. Such commercial laboratories have introduced the rebate abuse whereby in order to get business the laboratory splits fees with physicians and druggists. Their profit is small for the individual examination, and a large amount of work done quickly is necessary for their existence. The result is that work which may be highly important to the health of individuals is done by persons not properly qualified. It would be well if some other cities would follow the lead of New York in efforts to stamp out the commercial clinical laboratories.

WE get very tired of hearing from out-of-state essayists, invited to appear before the Indiana State Medical Association, that they do not want their papers, addresses, or discussions published because they want to use the material several times before it is given publicity through the medical press. We confess that from experience we know it is difficult to prepare a separate paper or address each time an invitation is accepted to appear before a medical society, but we think it should be done when the invitation comes from a prominent organization like a state medical association and has been accepted. Furthermore, we would like to call attention to a rule to the effect that all papers and addresses delivered at annual sessions of our Association become the property of the Association, and any person who appears upon the program should feel morally bound to abide by the rule. Apropos, we may add that we are not in favor of inviting out of the state speakers so freely, for we have enough good talent right in Indiana, and if two guests are invited to our annual sessions that is enough!

A wail has gone up concerning the broadcasting of music and speeches furnished by Victrola record. Well, we would rather have that than some of the stuff that comes over the radio that is not considered "canned" or in convenient commercial packages. We have in mind some of the so-called health talks by representatives of the pseudo-medical cults, the patent medicine manufacturers, physical culture exponents, and food faddists. In fact, it has reached the point where we would rather spend an evening listening to a high-class Victrola program of our own selection than listen to an evening's radio program that about nine times out of ten is made up of the most atrocious musical programs, humorless dialogues, like most of that by the over-rated Two Black Crows, and the uninteresting gibberish advertising a new cigar or somebody's cough drops. Radio broadcasting is getting so commercialized that many people are becoming disgusted and are abandoning their radio sets. Radio sales will fall off in the near future unless something is done to change the policies of some of the broadcasting stations that sacrifice everything to commercialism.

IN Australia twelve of twenty-one children inoculated last January with toxin-antitoxin at one time died within the next two days. Fortunately an extensive investigation as to the cause of the fatalities has shown beyond reasonable doubt that the deaths were due to an unfortunate contamination of the product used, and not to an inherent fault in the method of immunization. Such accidents, as the *Journal of the A. M. A.* says, are avoidable by proper care in producing and marketing the products and correct technique in their use. The methods of modern science are potent methods and hence are neither fool nor accident proof. Unfortunately, if only one accident in ten thousand cases occurred, the various anti- and obstructionist societies opposed to scientific medicine will make much ado about it, and numbers of thoughtless people may be led astray by the obstructionists twisting of circumstances to suit their own purposes. There is an old saying that there is absolutely nothing sure in this world except death and taxes, and, as the *Journal of the A. M. A.* well says, "millions of persons are transported on railroads and occasional accidents kill hundreds. Millions of children have been inoculated safely against smallpox and diphtheria, but occasional accidents result in death. As in other cases, the causes must be sought and if possible removed. Apparently human beings, being what they are, some accidental deaths are inevitable."

PHYSICIANS are entitled to a refund for taxes paid upon income from which was *not* deducted expenses of attending medical society meetings during the last five years. However, as an attorney advises us, unless you keep a set of books that includes all that you expended in attending medical meetings, or unless you can produce receipted bills covering expenditures, you will have a difficult time in proving to the treasury department officials that you are entitled to a rebate. This brings up the question of the need for a well-kept set of books covering both income and expenses, and the observation that the average physician is rather careless in this matter. It is doubtful if there is any considerable number of physicians, particularly those in general practice, who have a definite knowledge as to total income. This is not due to any desire on the part of the physicians to deceive the government as to income, but rather to the general carelessness that prevails among physicians in keeping records of any kind. Don't think because an income tax inspector has not called upon you and asked you to produce records for the past five years that he will not do so one of these fine days when you least expect him, and it will go hard with you if you cannot produce the necessary evidence to satisfy him that your report of income and expenses is correct. Not a few men have been penalized for unintentional false reports, and among the number are some physicians, and the penalty is not a mild one.

SOME of the Indiana newspapers of large circulation spasmodically carry some of the most fraudulent, deceptive or misleading medical advertising found anywhere, even in periodicals that make no claim for respectability. In talking with the advertising manager of one of these newspapers we were told that he could not afford to turn down such profitable contracts, and especially when competitors were quite willing to have such business. In other words, that is a frank admission that it is a question of commercial gain and not one of a high type of newspaper ethics and regard for the protection of the public. We had hoped that with the formation of the National Association of Advertisers, and the adoption of a policy that deprecates the taking of medical advertising contracts, some influence would be brought to bear on Indiana newspapers to "clean up", but our hopes have been in vain. However, there is one way, as pointed out in previous numbers of THE JOURNAL, in which pressure can be brought to bear, and that is through the influence of merchants, aided by Better Business Bureaus, who can refuse to patronize those newspapers that do not protect the public against imposition and fraud which encourage taking money away from honest and trustworthy merchants. If the profit from objectionable advertising is more than offset by a loss of highly desirable advertising, a publisher will change his policy, and not often it is touching the balance sheet in this way that makes him be good.

WELL, the election is over, and a lot of we Republicans in Indiana who voted for Hoover but did not vote the straight state Republican ticket because we felt that we had had enough of rascality, still believe in bowing to the will of the majority. The Hoover landslide carried everything with it, the good and the bad, and but for that there would have been a different tale to tell in Indiana. However, there are indications, as evidenced by the character of the vote in Indiana, that, like the handwriting on the wall, point to the desires of a large portion of the Republican voters in Indiana. If the new regime interprets the message correctly and acts accordingly there will be a restoration of the confidence placed in representative government.

To our notion election for purely county and state offices should be entirely independent of election for national offices. In no other way is it possible to secure the honest expression of people as to choice. It may be argued that the voters in the last election had an opportunity to split tickets, but in reality we might as well have been forced

to vote a straight ticket, as not sufficient time was given for much else, and many voters reluctantly voted a straight ticket because they were afraid if they attempted to split the ticket they would lose their votes. Voting machines may have expedited voting, and in particular the final count, but they are detrimental to the expression of honest opinion when the election judges insist that you shall take no more than one minute to cast your vote and force you out of the booth at the end of a minute whether you have voted or not.

MEDICAL men individually and collectively should fight shy of the lay health organization. Knoxville, Tennessee, has had an experience that should serve as a warning. The story is a long one and has to do with an attempt to establish a socialistic movement that is impractical because it attempted to furnish free medical and surgical services to all, irrespective of financial or social status in life. The reputable medical men of the profession of the city were dragged into the enterprise through specious pleas concerning the aims and objects of the health center, but it soon developed that these medical men were merely puppets at the beck and call of the lay organization and that their only function was to treat any and all patients coming under their hands and any attempt to correct abuses was checked promptly. Patients from far and wide came to the clinics and were given attention whether able to pay or not. The local community chest, and appropriations from city and state were drawn upon for finances. Finally it became necessary for the medical profession of Knoxville to make the fact known that the health center was pauperizing and making dependent a large class of people, and that the taxpayers were paying unjustly for service not justified. As a last resort the medical men refused to serve and the clinic was forced to close for lack of a staff. It was the united medical profession of Knoxville which effectively put this very obnoxious and incompetent institution out of business.

In various sections of the country similar efforts are being put forth to establish health centers, and it is just as well that the reputable medical men of the country be on their guard against having anything to do with such institutions, for it is a species of paternalism that will work to the detriment of the body politic as well as the medical profession.

THE report of the Committee on Nursing Education to the House of Delegates of the Michigan State Medical Society at its Detroit session in September, and adopted, is comparable to the report that might come from a committee investigating the subject in almost any state in the Union. Among some of the conclusions drawn are the following: Much of the mutual confidence of the nurse and patient is gone; she refuses to go to the country; to care for contagious diseases; or to do night duty; and many will take hospital cases only. Twelve-hour duty is in vogue today, no matter how easy the case, and when more care is needed two nurses must be employed, a hopeless arrangement for many people. The committee believes that nurses are over-educated. Whether it is the amount of learning or the manner in which it is acquired, it is more difficult to get the desired service from the higher trained nurses. The high entrance requirements and the elaborate training given have helped to increase the cost of nursing to a point which is higher than the patient can afford. The committee then presents the following principles for endorsement: 1. Nurses are helpers and agents of physicians, not co-workers or colleagues. 2. Physicians should have a part in the direction and training of nurses and in its limitations, as should the hospitals which give the training. 3. The training of nurses should be simplified and the time of undergraduate training reduced to not more than two years. 4. The apprenticeship system must be maintained. 5. The cost of nursing can be reduced by the introduction of instruction and simple nursing technic in our public schools so that home nursing by members of the family can be available to a greater degree by shortening the present training course, by the establishment of more hospitals, and by the more frequent use of group and hourly nursing. The committee believes that the power to license nurses should be in the hands of a non-political board of educators assisted by an advisory group of physicians and nurses.

ISN'T it about time for physicians to get over the idea that it is beneath their dignity to have anything to do with politics or legislation affecting their interests? They are quite willing to let someone else do the work for them, but most of them are unwilling to turn a hand to help themselves even when necessary for their own salvation. The time has arrived when physicians will have to take some hand in shaping legislation that affects them or they are going to be wiped out as independent practitioners. What is being done to destroy the independence of the medical man also is injurious to the public, but the public is being fed up by a lot of high pressure salesmanship on the part of members of the pseudomedical cults and medical pretenders, to say nothing of the specious pleas of welfare workers of one kind or another who have false Utopian ideas concerning some kind of free medical and surgical services for all. At our legislative sessions there are representatives of all those who are antagonistic to the progress of scientific medicine and the welfare of regular medical practitioners. Oftentimes these

representatives are the paid representatives who are on the job constantly to look out for the interests of their employers. Medical men look to a healthy public sentiment to swing the pendulum in their direction, but the odds are against them. Oftentimes it is better to fight your enemies with their own weapons and then go them one better in the scrimmage. We must lay aside all prejudice against labor in our own behalf, and throw aside the halo of professional dignity insofar as it pertains to objections to employing lobbyists or their equivalent to represent us in the law-making halls. During the session of the Indiana legislature we ought to have a paid, able and shrewd representative on the ground every minute to represent us when any problem presents, and at all times to work intelligently and effectually in the interests of medical progress and the economic standing of medical men in general. Such a man should be secured for the coming session of our legislature, an all-time man, and if his salary cannot be paid from the treasury of the Indiana State Medical Association, then pass the hat and raise the money.

DEATHS



Dr. Charles F. Neu, Indianapolis

Charles F. Neu, M.D., one of the leading neurologists of the middle west, died October 10th, 1928, at the Methodist Hospital, Indianapolis, after an illness of several months duration.

Dr. Neu was born March 14th, 1866, at Middletown, Canada, of parents who had emigrated from their native country, Germany. He lived in Middletown eighteen years where he acquired a public school education, after which he entered the University of Western Ontario, from which he graduated April 16th, 1894, with a degree of M.D. After serving as interne in the General Hospital of London, Ontario, he entered general practice in that city, where he practiced for eight years. He then came to Indianapolis and for three years occupied the position as pathologist at the Indiana State Hospital for the Insane. He then severed his connection with this institution and entered private practice in Indianapolis, confining his work to neuropsychiatry. He soon established himself as a very able neurologist. Dr. Neu was recognized as an authority in his specialty and contributed liberally to the literature on neurological subjects.

He was a member of the American Medical Association, the Indiana State Medical Association, Central Neuro-psychiatric Association and the Indianapolis Medical Society, for which he had served as president. At the time of his death, Dr. Neu was professor of neuropsychiatry in the Indiana University and a member of the University staff, Methodist Hospital staff and the staff at St. Vincent's Hospital.

Dr. Neu had been very active in Masonry, being a thirty-second degree Scottish Rite Mason. He was married to Mary Ellen Jones, of Columbus, Wisconsin, December 25th, 1907, who survives him. He was buried at Columbus, Wisconsin.

Sarah Morrow, M.D., of Richmond, died November 13, aged eighty-two years.

G. W. Frederick. M.D., of Kokomo, died November 16, aged sixty-seven years. Dr. Frederick graduated from the Medical College of Ohio, Cincinnati, in 1885.

Robert J. Carroll, M.D., of Hammond, died November 16, following a four weeks' illness. Dr. Carroll was fifty-eight years of age. He graduated from the Medical College of Ohio, Cincinnati, in 1892.

Alva J. Kimmell, M.D., of Hudson, died October 21, aged seventy-one years. Dr. Kimmel graduated from the Miami Medical College, Cincinnati, in 1886. He was a member of the Steuben County Medical Society, the Indiana State Medical Association and the American Medical Association.

EDWARD L. DEWEY, M.D., of Whiting, died October 21, aged sixty years. Dr. Dewey had been a practicing physician in Whiting for thirty-two years. He was health commissioner for the city at the time of his death. Dr. Dewey graduated from the Jenner Medical College, Chicago, in 1904. He was a member of the Lake County Medical Society, the Indiana State Medical Association and a Fellow of the American Medical Association.

NEWS NOTES AND PERSONALS

Anything in the line of physicians' supplies or equipment may be obtained from advertisers in THE JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION. Patronize these advertisers, for it means a continuance of their advertising patronage, and the latter means a larger and better Journal for you.

DR. CHARLES ARBURN, of Wadesville, broke his left arm November 7.

THE Jefferson County Medical Society held its regular meeting at Madison, October 29.

DR. P. G. MOORE, city health officer of Wabash, recently entered upon his sixty-third year in the practice of medicine.

DR. A. J. COOK, of Flora, and Edythe M. Mabitt, of Lebanon, were married November 21, at Greenwood. They are now residing in Flora.

DR. ERNEST SACHS, of St. Louis, presented a paper on "The Diagnosis and Treatment of Brain Tumors" at the November 13th dinner meeting of the Muncie Academy of Medicine.

AT the November 6th meeting of the Indianapolis Medical Society case reports were presented by Drs. Homer W. Cox, Dr. William F. Clevenger, Dr. Lehman Dunning, Dr. C. B. DeMotte, Dr. J. N. Collins, Dr. Ralph Chappell and Dr. S. J. Copeland.

THE 1928 Nobel prize for medicine was awarded to Dr. Charles Nicolle, director of the Pasteur Institute at Tunis. He was given it for his work on infectious fevers, particularly those caused by micro-organisms so minute that they filter through the pores of unglazed porcelain.

MEMBERS of the Elwood Medical Society at their November meeting, held November 7, decided that they would not have office hours on Thursday and Sunday afternoons and evenings in the future. At the meeting Dr. F. M. Gastineau, of Indianapolis, presented a paper on "Skin Diseases."

THE second seminar of the Indiana University School of Medicine for this school year was held on Friday, November 23, in the auditorium of the medical school building. A social hour followed the program which included presentation of hospital cases, and three scientific papers.

THE regular monthly clinic program of the Welborn Hospital Clinic was held November 21. The program consisted of a case report by Dr. James Y. Welborn; a paper by Dr. W. R. Davidson, and a symposium on "Infection of the Mastoid" by Drs. K. T. Meyer, E. L. Boyd and M. Ravdin.

THE *Journal of Chemotherapy*, a quarterly, will be sent gratis to physicians interested in chemotherapy, research and the treatment of syphilis. For copies address the Dermatological Research Laboratories, 1720 Lombard Street, Philadelphia, or the Abbott Laboratories, North Chicago. Illinois.

A nation-wide educational campaign for the prevention of blindness and the conservation of vision among the industrial workers of America and among their families will be launched immediately as a joint effort of the American Federation of Labor and the National Society for the Prevention of Blindness.

DR. AND MRS. WILLIAM S. TOMLIN, of Indianapolis, have been traveling in Europe where they visited Edinburgh, Paris, London and Vienna. Dr. Tomlin has been doing a considerable amount of postgraduate work in various European clinics. They expect to reach their home in Indianapolis in time for the Christmas holidays.

DR. J. H. SHERWOOD, of Bedford, was elected president of the Third District Medical Society at the annual meeting held recently at New Albany. Dr. John Gibbons, of Bedford, was elected vice-president, Dr. Perry Woolery, of Mitchell, secretary, and Dr. W. J. Leach, New Albany, councilor for the distict. The next meeting will be held at Bedford in April.

AT the October 26th meeting of the Hendricks County Medical Society the following officers were elected for the ensuing year: President, Dr. Louis W. Armstrong, Danville; vice-president, Dr. F. C. Rust, Brownsburg; secretary and treasurer, Dr. W. T. Lawson, Danville. Dr. John Owens, of Indianapolis, presented a paper on "Difficulties in Diagnosis of Diseases of the Right Abdominal Quadrant."

THE next congress of the Pan-American Medical Association will be held in Havana, Cuba, from December 29th, 1928, to January 3, 1929. The program will include four orations upon the

subjects of surgery, medicine, pediatrics and tropical medicine. The oration on surgery will be given by Dr. William J. Mayo, the oration on medicine by Dr. Lewellys Barker. Papers will be read in both Spanish and English.

The Indianapolis Medical Society held its regular weekly meetings at the Athenaeum, November 13th and November 20th. The program November 13th consisted of papers by Dr. Robert M. Moore, Dr. Walter F. Kelly and Dr. Marie Kast. On November 20th, Dr. E. I. McKesson, of Toledo, Ohio, presented an address on "Modern Anesthesia; Modes of Action and Its Relation to Operative and Post-Operative Results."

At a meeting of the Montgomery County Medical Society, held October 25 at the home of Dr. and Mrs. Byron L. Lingeman, of Crawfordsville, Dr. Charles P. Emerson presented a paper on "Distinguished Men in Medicine I Have Known." By vote of the society, Dr. W. T. Gott, Dr. John N. Taylor, Dr. W. H. Ristine, Dr. B. F. Hutchings, Dr. E. H. Cowan, of Crawfordsville, and Dr. Charles T. Bronaugh, of New Ross, were made honorary members of the Society.

The Indiana University School of Medicine has established the new "Frank A. Morrison Ophthalmological Library," through the provisions of the will of the late Dr. Frank A. Morrison, whose bequest included approximately four hundred volumes devoted principally to the eye, but includes also a number of works on anatomy and kindred subjects. Along with Dr. Morrison's gift to the University other important gifts have been received.

Requests for appropriations of $339,467 and $332,392 for the next biennial term were asked for by the State Board of Health recently in its proposed budget filed with Lawrence F. Orr, chief examiner of the state board of accounts. During the last two fiscal years expenditures of the department were $212,946.19 and $225,586.49, respectively. An appropriation of $41,190 for rabies treatment and preventive work and $140,352 for infant and maternity work of the department were asked.

Dr. M. R. Combs, of Terre Haute, was honored in November by a birthday party given by the profession of the community. In addition to a handsome watch, he was presented with a parchment scroll inscribed with birthday greetings and signed by the one hundred twenty-eight physicians present. The address of the evening was on the subject, "Spinal Anesthesia" and was given by Dr. W. Wayne Babcock, of Philadelphia, whose friendship for Dr. Combs dates from their service together in the World War.

About seventy-five physicians from the thirteenth district held a meeting at Plymouth, November 1. The afternoon and evening sessions were devoted to lectures and discussions on various subjects of interest and value to the physicians. Addresses were presented by Dr. S. F. Morgan, of New Carlisle, Dr. Lee F. Kerrigan, of Michigan City, Dr. H. H. Martin of LaPorte, and Dr. A. S. Giordano, of South Bend. Dr. George Daniels, of Marion, Dr. A. C. McDonald, of Warsaw, and Mr. Thomas Hendricks also gave short talks. Elkhart was selected as the place for the 1929 meeting.

The United States Civil Service Commission announces open competitive examination for medical adviser and assistant medical adviser, applications for which positions must be on file with the Civil Service Commission at Washington, D.C., not later than December 29th. Examinations are to fill vacancies in the Food, Drug, and Insecticide Administration, Department of Agriculture, for duty in Washington, D. C., or in the field. Competitors will be rated on education, training and experience. Full information may be obtained from the United States Civil Service Commission, Washington, D. C.

Dr. Max Mason, former president of the University of Chicago, and Dr. William Allen Pusey, of Chicago, former president of the American Medical Association, and five other men who rank among the world's greatest scientists, recently have been appointed as the National Research Council's committee to co-operate with the officials of the Chicago World's Fair in developing the scientific theme of the city's centennial celebration. The committee includes Frank Baldwin Jewett, vice-president of the American Telephone and Telegraph Company, in charge of development and research, chairman; Gano Dunn, Dr. Simon Flexner, Dr. Vernon L. Kellogg and Dr. Michael I. Pupin.

The American Board of Otolaryngology held an examination in New York City, October 11th, when one hundred thirty applicants were examined, one hundred thirteen passing. An examination was held in St. Louis, October 15th when seventy-nine were examined, sixty-eight of whom were passed. The Board will hold an examination in Portland, Oregon, July 8th, during the session of the American Medical Association, and in Philadelphia in October preceding the American Academy meeting in Atlantic City. Those desiring information relative to the above may communicate with Dr. W. P. Wherry, Secretary,

Board of Otolaryngology, 1500 Medical Arts Building, Omaha, Nebraska.

In addition to the articles already enumerated the following have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association:

Abbott Laboratories:
Capsules Ephedrine Hydrochloride-Abbott, 3/8 grain.

Lederle Antitoxin Laboratories:
Tablets Whole Ovary-Lederle, 2½ grains.

Eli Lilly & Co.:
Antimeningococcic Serum Concentrated-Lilly.
Antistreptococcic Serum. Purified and Concentrated (Lilly).

Mallinckrodt Chemical Works:
Iso-Iodeikon.

Merck & Co., Inc.:
Optochin Base.
Optochin Hydrochloride.

H. K. Mulford Co.:
Mulford's Acidophilus Bacillus Blocks.
Tetanus Antitoxin (Bovine).

Parke, Davis & Co.:
Capsules Ephedrine Sulphate—P., D. & Co., 3/8 grain.
Capsules Ovarian Substance, Desiccated—P., D. & Co., 5 grains.

E. R. Squibb & Sons:
Tablets Protargentum—Squibb, 4.6 grains.
Tablets Solargentum—Squibb, 4.6 grains.

Swan-Myers Co.:
Syrup Ephedrine Hydrochloride (double strength)—Swan-Myers.

Nonproprietary Articles:
Ethylhydrocupreine.
Phentetiothalein Sodium.

SOCIETIES AND INSTITUTIONS

INDIANA STATE MEDICAL ASSOCIATION BUREAU OF PUBLICITY

October 29, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. A. Wishard, M.D., chairman; J. A. MacDonald, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held October 15 read and approved.

The newspaper article, "Competitive Athletics", was prepared for release Saturday, November 3.

The following requests for speakers were received:

Posey County Medical Society, New Harmony, Ind. "Economics". Speaker to be obtained.

October or November, Teachers' Institute, Fowler, Ind. "Diphtheria." Speaker to be obtained.

November 13—Tri-County Medical Society meeting, Columbus, Ind. "Congenital Syphilis." Speaker obtained.

November 1—Clinton County Medical Society, Frankfort, Indiana. "Pediatrics". Speaker obtained.

November 15—Elwood Kiwanis Club and Madison County Medical Society, Elwood, Ind. Speaker to be obtained.

Letter received from the Committee on the Cost of Medical Care and the secretary was instructed to have some physician who had given special study to this matter review this subject for the Bureau.

The following letter was received from the Executive Secretary of the Indiana Parent-Teacher Association:

"We will be very glad indeed to have the medical bulletins again this year. Beginning with the November first number of the parent-teacher bulletin we will be very glad to have them to send out. We will need about 800 copies of each issue.

"Assuring you the appreciation of the Parent-Teacher Association for this service, I am—."

The Bureau reviewed the Indiana news column in the *Journal of the American Medical Association.*

The following bills were approved for payment:

William P. Walker	$10.50
William P. Walker	1.00
	$11.50

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole November 5, 1928.

WM N. WISHARD, M.D.
Chairman.
THOMAS A. HENDRICKS
Secretary.

November 6, 1928.

Meeting called to order at 4:15 p. m.

Present: Wm. N. Wishard, M.D., Chairman; M. N. Hadley, M.D., and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held October 29 read and approved.

The release on "Ringworm" was again considered by the Bureau in revised form and was passed for publication with the condition that proper differentiation be made between the old-fashioned ringworm and this newer form of skin infection which is known as ringworm.

The secretary was instructed to obtain a medical dictionary for the office.

The following requests for speakers were made:

November 13—Tri-County Medical Society meeting, Columbus, Indiana. "Congenital Syphilis." Speaker obtained.

November 15—Elwood Kiwanis Club and Madison County Medical Society, Elwood, Indiana. Speaker to be obtained.

Posey County Medical Society, New Harmony, Indiana. "Medical Economics". Speaker to be obtained.

November 15—Muncie Exchange Club, Muncie, Indiana. "The Influence of Modern Business Life Upon Heart Disease." Speaker to be obtained.

Report on the following meeting was received:

November 1.—Frankfort, Indiana. Clinton County Medical Society. "Infant Feeding".

Letter received from the secretary of the Clinton County Medical Society saying that the principal of a school in that county desired the weekly releases. The secretary was instructed to obtain the names and write to the members of the Indiana State Board of Education saying that some of the principals of the state had expressed a desire for the weekly releases and asking the State Board to use these releases in any publication which is sent out to the principals and the teachers of the state.

Suggestion was made that the Bureau prepare an article upon "Undulant Fever" and that the facts in regard to Undulant Fever in Indiana be obtained from South Bend where a great deal of work has been done in combatting this new disease.

An article of the United States Public Health Service upon "Bright's Disease" was submitted to the Bureau and the Bureau instructed the secretary to place this article

in the hands of one of the members of the Bureau for detailed review.

The following bill was approved for payment:

Central Press Clipping Service.....$11.13

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole November 12, 1928.

WM. N. WISHARD, M.D.
Chairman.
THOS. A. HENDRICKS
Secretary.

November 12, 1928.

Meeting called to order at 4:45 p. m.

Present: Wm. N. Wishard, M.D., chairman; J. A. MacDonald, M.D., by proxy, and Thomas A. Hendricks. executive secretary.

The minutes of the meeting held November 6 read, corrected, and approved.

The release on "Ringworm" met the final approval of the Bureau and with the corrections and addition was passed for publication on Saturday, November 17. The proper differentiation was made between the old-fashioned ringworm and the newer form of skin infection which has been designated as ringworm.

The release on "Bright's Disease" was corrected for publication November 24.

The purchase of a medical dictionary for the office was considered and the secretary was instructed to get additional facts concerning the various dictionaries and present them to the committee at the next meeting. Those dictionaries being considered are: Dorland, published by W. B. Saunders Company; and Stedman's, published by P. Blakiston's Sons Co.

The following requests for speakers have been received:

November 15—Elwood Kiwanis Club and Madison County Medical Society, Elwood, Ind. Speaker to be obtained.

Posey County Medical Society, New Harmony, Ind. "Medical Economics." Speaker to be obtained.

November 15—Muncie Exchange Club, Muncie, Ind. "The Influence of Modern Business Life Upon Heart Disease." Speaker obtained.

Letter formulated by Bureau to be sent to Superintendent of Public Instruction of Indiana and the members of the State Department of Public Instruction requesting the right to publish weekly releases of the Bureau in the *"Indiana Education News"*, a monthly publication from the State Department of Public Instruction, or the *"Indiana State Teachers' Journal."*

The Bureau commented and voiced its approval of the following paragraphs in regard to diphtheria immunization contained in the monthly bulletin of the Parent-Teacher Association:

"The Board of Health is equipped to address public meetings in the interest of diphtheria immunization and to show motion picture films on the subject. Associations may write direct to the Board at Indianapolis. They will do all they can to help.

"But immunization of children against diphtheria is a matter entirely up to the parents and local physicians. All the State Board of Health can do, and all the parent-teacher association can do is to educate parents as to the need."

Letter received from the American Society for the Control of Cancer asking what work was being done in Indiana along that line.

Report to be made at next meeting on the pamphlet published by the Committee on the Cost of Medical Care.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole November 19, 1928.

WM. N. WISHARD, M.D.
Chairman.
THOMAS A. HENDRICKS
Secretary.

November 19, 1928.

Meeting called to order at 4:45 p. m.

Present: M. N. Hadley, M.D., Wm. N. Wishard, M.D., chairman, by proxy, and Thomas A. Hendricks, executive secretary.

The minutes of the meeting held November 12 read and approved.

The release, "Bright's Disease—Part II" was corrected and approved for publication on Saturday, December 1.

The release on "Ringworm" was broadcast over radio station WFBM on November 17.

The following requests for speakers were received:

November 20—Gyro Club, Indianapolis. Speaker obtained.

November or December—Meeting of foremen of factories for the purpose of discussing and instructing them in the prevention and first care of injuries. Muncie, Indiana. Speaker to be obtained.

Posey County Medical Society, New Harmony, Indiana. "Medical Economics." Speaker to be obtained.

The following reports on medical meetings were received:

September 20—Connersville, Indiana. Kiwanis Club. "The Effect of Modern Business on Heart Disease."

November 13—Columbus, Indiana. Tri-County Medical Society. "Congenital Syphilis".

The secretary was instructed to attend meeting of the Women's Department Club of Indianapolis which was to be addressed by Dr. William H. Walsh, former secretary of the American Hospital Association, who has recently completed a survey of the local hospital situation for the Indianapolis Foundation.

There being no further business, the meeting was adjourned.

The above minutes were approved in each separate part and as a whole November 26, 1928.

WILLIAM N. WISHARD, M.D.
Chairman.
THOMAS A. HENDRICKS,
Secretary.

WOMAN'S AUXILIARY

At the invitation of the councilor, Dr. E. E. Padgett, the Woman's Auxiliary to the Seventh District Medical Society was organized at Martinsville, October 30th. Following a talk by Mrs. F. W. Cregor, explaining auxiliary ideals and aims, Mrs. David Ross, of Indianapolis, was elected councilor, Mrs. Robert H. Egbert, Martinsville, secretary, Mrs. J. C. Stafford, Plainfield, treasurer. Mrs. Walter L. Porteus, of Franklin, chairman for Johnson county, and Mrs. Rilus Jones, Clayton, chairman for Hendricks county. As the ladies of Morgan county plan to organize an auxiliary, no chairman was named. Marion county is represented by the president of the Auxiliary to the Indianapolis Medical Society, Mrs. David Ross, whose successor will be elected in January. An Auxiliary to a district medical society facilitates organization in the component counties, and gives opportunity for an intimate exchange of auxiliary ideas and work at the biannual meetings. Mrs. E. M. Pitkin was chairman of the hospitality committee which functioned so smoothly for the entertainment of the guests; a card party and organization details in the afternoon, then dinner, and a musicale left all with happy memories of the day.

The auxiliary to the Indianapolis Medical Society met

in the parlors of the City Hospital, November 16th. The program included readings by Mrs. F. L. Pettijohn, and Scotch songs by Miss Martha MacDougall.

November 16th and 17th Mrs. Cregor was in Chicago attending the conferences of national officers of the auxiliary. Mrs. Allen H. Bunce, Atlanta, Georgia, president of the Auxiliary to the American Medical Association, is devoting much time to "budgeting" expenditures in order to place this rapidly growing organization on a business basis. Mrs. A. B. McGlothlan, St. Joseph, Missouri, national chairman of Hygeia, announced the final plans in the Hygeia contest, which began September 1st and ends March 31st, 1929. A prize of $500 in cash will be given to the state auxiliary that sends in the largest number of paid Hygeia subscriptions above one thousand; furthermore, Hygeia will give twenty-five dollars to any county auxiliary that sends in one hundred subscriptions, exclusive of group orders for fifty or more subscriptions. As regular commissions will be paid on all subscription, this is an opportunity for county auxiliaries to develop treasuries. Twenty-five dollars for one hundred subscriptions means twenty-five dollars prize money plus one hundred twenty-five dollars commission money. Mrs. Ben Davis, of Duluth, president of the Minnesota auxiliary, brought with her a check for one hundred dollars, a gift from the Minnesota auxiliary to the national auxiliary; it is a part of the profit realized from the "coffee shop"—read about this in the Bulletin!

Much time is being spent on the revision of the Constitution and By-laws, of which committee Mrs. Morris radio health talks will find in each issue of the American Medical Association journal a list of medical broadcasts for the week, morning h alth tall s, even health hints from *Hygeia*.

By this time all probably have received copies of the *Bulletin of the Woman's Auxiliary to the A. M. A.* Your state president begs all to read this bulletin carefully, Fishbein, of Chicago, is chairman. Those interested in and develop a knowledge of what the auxiliary is doing in many states, so that Mrs. W. R. Davidson will find well-informed co-workers when she becomes state president, January 1st. This Bulletin contains so much information that one marvels at the editing ability of Mrs. Bunce.

A letter from Mrs. William S. Tomlin, Indianapolis, now in Vienna, Austria, tells of a Woman's Auxiliary to the American Medical Association of Vienna, organized in the late summer; the women are very enthusiastic as the organization is particularly helpful to the women themselves, as any one who has lived under foreign conditions can realize.

The printed reports of the Gary meeting soon will be ready for distribution; this delay is regretted, but there have been many contributing factors, among them unanswered letters.

Your president takes this opportunity to thank all who have assisted her during her term of office, whether by encouragement or co-operation. Especial thanks goes to Dr. Albert E. Bulson for his patience, his understanding and his editorials. We can feel proud of the start we have made, and can look forward to the time when the Indiana State Medical Association will be glad it encouraged a Woman's Auxiliary.

This president now "signs off".

Respectfully submitted,
MRS. F. W. CREGOR.

HENDRICKS COUNTY MEDICAL SOCIETY

Danville, Indiana,
November 6th, 1928.

The Hendricks County Medical Society met October 26th, at Danville, Ind., with nearly all members present. On invitation Dr. John Owens, of Indianapolis, read a splendid paper on "Difficulties in Diagnosis of Diseases of the Right Abdominal Quadrant." The discussion was participated in by nearly every member present. Officers for the ensuing year are: President, Dr. Louis W. Armstrong, Danville; vice-president, Dr. F. C. Rust, Brownsburg; secretary and treasurer, Dr. W. T. Lawson, Danville.

Respectfully
W. T. LAWSON, M.D., Secretary.

TIPPECANOE COUNTY

Lafayette, Indiana,
November 8, 1928.

The Tippecanoe County Medical Society met in regular session at the Hotel Lahr, dinner at 6:15 P. M., followed by the address of the evening, "Some Phases of Heart Failure" by Dr. Robert M. Moore.

Dr. Moore showed clearly the two forms of angina, giving a very clear discussion of the persistent symptoms and condition of each.

The audience consisted of more than fifty, showing unusual interest in the subject and the way it was presented. Many questions were asked at the close of the address, bringing out a number of points on heart failure and clearing up questions in the minds of those present.

The business session followed consisting of the reading and approval of the minutes of the October meeting, allowing one bill of $2.00 for guest's meals. The announcements of future meetings and the reading the second time of the applications for membership of Dr. William R. Ward and Dr. Russel A. Flack. Motion was made and carried that we suspend the rules of a secret ballot for election and elect by acclamation. Motion was made and carried unanimously that the secretary cast the ballot of the society for Drs. William R. Ward and Russel A. Flack to become members of our society.

By consent, arrangement for a meeting with the attorneys and dentists will be arranged for a future date, the subject to be "Medical Jurisprudence." The medical profession is invited to be guests at Purdue University December 25th at a meeting held by the American Pharmaceutical and American Drug Manufacturers Association.

Motion to adjourn was carried.

Dr. Moore gave a very interesting clinic from 3:00 to 5:30 P. M at St. Elizabeth Hospital.

Dr. Moore took up the subject of heart disease from three points stating that the diagnosis can be readily made and quite satisfactorily by this system: first, etiology; second, structural changes; third, functional disturbances.

Under etiology he presented seven varieties, first, congenital; second, rheumatic; third, thyroid; fourth, syphilitic; fifth, hypertensive; sixth, sclerotic; seventh, nervous heart.

Under the second point we have the various valvular and paricardial changes.

Under the third point we have the various arrhythmias, or functional disturbances. He emphasized the fact that we treat the functional disturbances and not the structural changes. Also we can prevent the causes to a great extent.

Case No. 1 was that of a lady who gave a history of rheumatic heart disease giving symptoms years afterwards. Auricular fibrillation is present in many of these cases and is a fine thing. Keep the heart fibrillating.

Case No. 2 was a child three years old giving a history of a cold with probable tonsillitis sometime previous, who now has a beginning mitral insufficiency. In these cases among other important things is the history of colds with a high white cell count.

Case No. 3 was that of a man twenty-five years of age who has been a laborer, handling cement. Lately he has noticed his heart beating fast and hard when he climbs the stairs. No symptoms could be located and his heart is doing well today. Diagnosis was rather difficult.

Case No. 4 was one of a lady fifty years of age who has

(Continued on Page 550)

November—R. H. Moser, M.D., of Indianapolis—"Acute and Chronic Indigestion and Treatment for Same."

December—Chas. P. Emerson, M.D., of Indianapolis.

T. D. PETERS, M.D.
President.

E. H. BRUBAKER, M.D.
Secretary.

VANDERBURGH COUNTY MEDICAL SOCIETY

Evansville, Indiana.

The regular monthly meeting of the Vanderburgh County Medical Society was held at the Y. M. C. A. auditorium, Tuesday, November 13,at 8:00 p. m.

Dr. Henry J. John, of the Crile Clinic, Cleveland, Ohio, presented an exceedingly interesting and worthwhile talk on "Diabetes". A number of interesting lantern slides were shown of the blood sugar curves on patients under insulin therapy. To any society desiring to hear the subject of "Diabetes" presented in such a manner as to be understood by the general practitioner, we recommend Dr. John. A number of physicians from the neighboring counties were in attendance.

Plans were discussed for the state meeting which is to be held here next fall. The Vanderburgh County Medical Society is hoping to be able to put on the best state meeting ever held in Indiana, and if hard work is going to do it, we are going to succeed.

KEITH T. MEYER, M.D.
Secretary.

MADISON COUNTY MEDICAL SOCIETY

Anderson, Indiana.

Whether you believe in state medicine or not, it is a certainty that it is taking a foothold that will carry it far beyond its present limitations. "Retail vs. Wholesale Life Saving" was a recent article in the *Journal of the A. M. A.* At every medical meeting one attends they tell of the necessity of doing many things that seem beyond the range of the individual physician. If beyond his range it often is ignored or looked upon with ill favor.

Infectious diseases are a community problem. Tuberculosis and cancer cases are being shifted to centers for care and treatment. Poliomyelitis should have the immediate care and treatment of experts with experience in their management. Chicago now has one hundred twenty-four health agencies. Sixty-nine per cent of the beds in the Veterans Bureau hospitals are occupied by ex-soldiers being treated for conditions not due in any way to service causes. The great majority of cases of hydrophobia treated at the expense of the state at Indianapolis could afford to pay for treatment at home. The abuse of the Riley Hospital privileges cost Madison County taxpayers over $40.00 a day last year. Some organizations are entirely idealistic, but others are trying to work out a practical community health program.

The Rockefeller Foundation is sponsoring programs all over the world, and in Drake County, Ohio, Dr. M. E. Barnes, of the Ohio State Department of Health, and director of training for health officers, and member of field staff of the International Health Division of the Rockefeller Foundation, has become internationally known for his work. He was the guest of the Madison County Society on Tuesday evening, November 20th, at a dinner meeting at the Grand Hotel at 6:30 p. m. and told of some of his experiences in wholesale health methods.

Respectfully,

M. A. AUSTIN, M.D.

BOOK REVIEWS

Books received will be acknowledged in this column. Selections will be made for more extensive review in the interest of readers and as space permits. Any information concerning these books will be supplied on request.

Books received since November 1, 1928:

THE ELEMENTS OF THE SCIENCE OF NUTRITION. By Graham Lusk, Ph.D., Sc.D., Professor of Physiology at the Cornell University Medical College, New York City. Fourth edition, reset, 844 pages. Cloth. Price, $7.00. W. B. Saunders Company, Philadelphia and London, 1928.

NEUROLOGICAL EXAMINATION. By Charles A. McKendree, M.D., Associate, Department of Neurology, College of Physicians and Surgeons, Columbia University. Foreword by Henry A. Riley, M.D. 280 pages with 88 illustrations. Cloth. Price, $3.25. W. B. Saunders Company, Philadelphia and London, 1928.

GENERAL MEDICINE. Practical Medicine Series. One of a series of eight year books, issued at various intervals during each year. Edited by George H. Weaver, M.D., Lawrason Brown, M.D., George R. Minot, M.D., William B. Castle, M.D., William D. Stroud, M.D., and Ralph C. Brown, M.D., 831 pages. Cloth. Price of this volume, $3.00. The Year Book Publishers, Chicago, 1928.

OPHTHALMIC OPTICS. By Alfred Cowan, M.D., assistant professor of ophthalmology in the Graduate School of Medicine, University of Pennsylvania. Second edition. 262 pages with 121 illustrations. Cloth. Price, $3.50. F. A. Davis Company, Philadelphia, 1928.

REVIEWS:

ULTRA-VIOLET RAYS. By Percy Hall, M.R.C.S., L.R.C.P. (London). Actino-therapist, the Mount Vernon Hospital, London and Northwood, etc. Introductions by Sir Henry Gauvain, M.A., M.D., M.C. (Camb.), F.R.C.S., and Leonard E. Hill, M.B. (London) F.R.S. Third edition, 236 pages. Illustrated. Cloth. Price, $4.50.

This is the third edition, rewritten and enlarged, of a book that first appeared in England in 1924, and American editions of which have appeared in 1924 and 1928. In introducing the work one writer says that unthinkingly the value of sunlight always has been accepted, but that has been rather a matter of instinct than of reason. It is only comparatively recently that systematic research on an extensive scale has placed intensive light treatment on a solid basis by differentiating the properties of various wave-lengths of radiant energy in the treatment of disease. Scientific researches have succeeded shrewd clinical observations. In the present state of our knowledge ultra-violet rays are both the most important and most interesting of those existing in the solar spectrum, and direct bactericidal action long has been well known, but of greater importance than the fascinating interest is their effect on deep-seated and inaccessible lesions to which by no conceivable means are they capable of penetrating. It has been demonstrated that, by the skin or other tissues, ultra-violet radiation possesses the property of greatly enhancing the bactericidal power of the blood; a discovery of the highest interest and importance. These clinical and scientific discoveries concerning the beneficial effects of the ultro-violet rays have brought about not only the manufacture and merchandising of a variety of equipment, but exaggerated claims as to beneficial effects, and a too widely accepted employment of the apparatus by those unfitted by training or experience to use it. As the author has well said, the

proper use of the ultraviolet apparatus demands knowledge and skill not easily acquired, and certainly not to be gained merely by the perusal of instrument-maker's catalogs. The rapid spread of its use by nurses and others, if uncontrolled by medical men who have specially studied actinotherapy, who have no medical knowledge or training and are utterly unable either to diagnose disease or properly observe and understand the significance of signs and symtoms as they occur, is greatly to be deplored. To place such a powerful weapon in the hands of such people is to invite disaster, and is well calculated, should ill-results occur, to cause such a revulsion in its disfavor as to put the method back a decade, for the blame would inevitably be put upon the remedy rather than upon those who had, through ignorance or otherwise, misapplied it. After discussing the means for securing ultra-violet light, including the physics, physiology, pathology and hygiene of light, the author devotes a number of chapters to the technique of administration and dosage, together with therapeutic indications and results obtained from treatment. Throughout the book there is a tone of conservatism that seems commendable, and the author, unlike some of the enthusiasts, frankly states that ultra-violet therapy has its limitations, which he tries to define. He does display an enthusiasm that seems justified in view of his results in certain cases, and from his large experience he is able to advise intelligently as to when, how and during what length of time the ultra-violet rays should be employed. This information is put clearly and concisely into the hands of the readers in the hope that the treatment will be found both rich in promise and fruitful in fulfillment.

DISEASES OF THE EAR, NOSE AND THROAT. By Wendell C. Phillips, M.D., ex-president, American Medical Association; formerly professor of otology, New York Post Graduate Medical School and Hospital; Surgeon to the Manhattan Eye, Ear and Throat Hospital, etc. Seventh revised and enlarged edition, illustrated with 615 half-tone and other engravings. 922 pages. Cloth. Price $9.00. F. A. Davis Company, Philadelphia, 1928.

This is the seventh revised and enlarged edition of a well-known textbook by a well-known teacher and clinician of wide experience. Its selection as a standard textbook by a large percentage of the medical schools of the country is in itself a recommendation for which the author may be proud. This new edition has been subjected to many changes to eliminate methods and procedures which have become obsolete and to add new material required to bring the book up to date. New chapters have been added containing recommendations concerning office equipment, with illustrations of improved paraphernalia for the examination of ear, nose and throat patients. Chapters have been rewritten discussing the newer tests of hearing, including audiometer tests, recent developments for the study of infantile mastoiditis, and nasal sinus infections. The improved operative technic of submucous resection, and several other operations; the use of actinic rays, the latest developments in bronchoscopy and esophagoscopy, and an abundance of new illustrations to clarify the text. In fact the book is a practical, comprehensive consideration of otolaryngology, including etiology, pathology, bacteriology and treatment of the various diseases or abnormalities from a modern up-to-date standpoint.

CLINICAL MEDICINE. By Oscar W. Bethea, M.D., Ph.G., Professor of Therapeutics, Tulane Graduate School of Medicine; Professor of Clinical Therapeutics, Tulane School of Medicine, New Orleans, La. 700 pages. Cloth. Price $7.50. W. B. Saunders Company, Philadelphia and London, 1928.

No matter how many textbooks on clinical medicine we have, it seems as though there is a place and a need for others, and this work of Bethea's fills a place not occupied by any other book or series of books on medicine, for it is adapted to the physicians who are called upon to care for the great majority of patients who are sick in their own homes and among conditions offering limited facilities to aid the physician in his efforts. In this respect it differs from the books relating to the practice of medicine based on work in fully equipped hospitals or the homes of the wealthy where every advantage of modern science is available. The author has succeeded in his avowed intention of putting into one volume, of moderate size, the latest and most generally accepted information as to the diagnosis and treatment of about one hundred of the most common diseases coming within the province of internal medicine. That the book is practical throughout is a point in its favor, for unproven theories and speculative discussions have been omitted. Obsolete methods of treatment and procedures likewise have been omitted in the effort to make the book practical and up-to-date. It is an excellent work for the student and general practitioner.

THE EXTRA-OCULAR MUSCLES. A Clinical Study of Normal and Abnormal Ocular Motility. By Luther C. Peter, A.M., M.D., Sc.D., Professor of Ophthalmology in the Medical Department of Temple University, etc. 294 pages, illustrated. Cloth. Price $4.00. Lea and Febiger, Philadelphia, 1927.

A knowledge of the ocular muscles is technical and hard to understand. This is due to the fact that so many writers complicate the subject with long technical or theoretical considerations, and the student has the greatest difficulty in grasping the salient points of the discussion. The author of this textbook, through long experience and teaching, has appreciated the difficulties encountered and has attempted, and accomplished with signal success, the simplification of the whole subject so that the student not only understands the theory and principle of the function and correlation of functions of the ocular muscles but he is able to make practical application of the knowledge. The book is divided into five parts, the first dealing with the anatomy and physiology, the second with heterophoria, the third with heterotropia or concomitant squint, the fourth with paralytic squint, and the fifth with nystagmus or talantropia. Prognosis and treatment in the various abnormal conditions is dealt with in a concise yet practical way. We have no hesitation in recommending the book as being a most trustworthy treatise on the extra-ocular muscles.

DIATHERMY. By Elkin P. Cumberbatch, M.A., B.M., M.R.C.P. Medical officer in charge, electric department, St. Bartholomew's Hospital, etc. Second edition. 331 pages. Cloth. Price $7.00. The C. V. Mosby Company, St. Louis, 1928.

This second volume of an English work on diathermy is a complete revision of the former edition, necessitated by the rapid progress which has been made in recent years in the medical and surgical uses of diathermy, and in the design of the apparatus and its use. In reality, the field in which diathermy seems applicable has been increased greatly, and there has been a great improvement in the methods of procedure as also in the results obtained. This has been due in a large measure to the natural progress that occurs in the employment of any relatively new procedure. Perhaps one of the greatest advancements that has been made is the use of diathermy in many of the diseases peculiar to women, and in others due to infection by the gonococcus where diathermy seems almost a specific. The treatment is especially beneficial in the treatment of arthritis due to gonoccocal infection. The surgical uses of diathermy also have been enlarged, and there has been great improvement in the equipment

employed. The author has drawn from his own wide experience in dealing with the subject under consideration, though he also gives credit for conclusions drawn from the experiences of many of his confreres who likewise have had much experience in diathermy treatment. Under medical diathermy the author discusses the treatment of subnormal temperature and efficient physiological activity; diseases of the urogenital organs in women; diseases of the urogenital organs in men; disease of joints, bones and fibrous tissues; diseases of the oral system; diseases of the cardiovascular system; diseases of the alimentary system; diseases of the respiratory system; and diseases of the eye. The chapters devoted to the use of high-frequency currents in surgery discuss the electrothermic methods of surgery, including diathermic coagulation of abnormal tissue, circumvalation, the combination of coagulation with cutting by the knife, as well as the snare, coagulation, the use of high frequency currents for cutting, and electrodessication, electrothermic methods in the treatment of malignant diseases and non-malignant growths and other forms of morbid tissue. The book should prove of practical value to any physician no matter what his line of practice. It is well illustrated.

THE EYE. By C. W. Rutherford, M.D., F.A.C.S., former associate in ophthalmology, Indiana University School of Medicine; now ophthalmologist for the medical school of Iowa University. 404 pages, with 305 black and white figures and 12 original colored plates. Cloth. Price $7.50. D. Appleton and Company, New York, 1928.

We feel that we can do no better than quote the author's preface concerning this excellent book for students and practitioners of medicine: "The needs of the general practitioner and student of medicine have had first consideration in the preparation of this text. The arrangement of the contents facilitates systematic study, and each subject is complete under the plan of presentation. The advantages of a work of reference and of a teaching text are combined.

"The practice of ophthalmology is based upon the broad foundations of clinical medicine. The visual apparatus is a part of the body, and not a dissociated feature. The structures of the eye and the orbit may express their own diseases primarily, they may be affected secondarily, and they may, by peculiar behavior, guide the diagnostician to a remote lesion.

"Diseases of the eye obey common laws. Their successful management requires some knowledge of the eye and its environments. For that reason, the essentials of the anatomy have been stated as an introduction to each section. The commoner diseases of each structure have been described carefully, while those of less frequent occurrence have been discussed as an aid to differential diagnosis. Free references have been made to ocular evidences of general diseases, since they are important in diagnosis. The latest established views and opinions have been presented, while controversial discussions occupy little space.

"The text is the product of the experience of the author and of the teaching of those who have contributed to the advancement of medical knowledge by personal communications, in literature and at the sessions of the learned societies. Few direct references have been made."

FOLKLORE OF THE TEETH. By Leo Kanner, M.D., of the Yankton State Hospital, Yankton, South Dakota. 316 pages. Cloth. Price $4.00. The MacMillan Company, New York, 1928.

The title describes this book. It is the folklore of the teeth, describing the superstitions and traditions, proverbs, folksongs, legends, charms, invocations, the pathologic and therapeutic beliefs and measures as centered upon the teeth; their development, number and position, their diseases, their loss, their use outside of the oral cavity and the various forms of their mutilation. No doubt the book will prove interesting to those who are interested in the vagaries of cruelty or imagination. As the author well says, "the time of witchcraft and totemism, mythology and divination, at least in the civilized sections of our globe, has gone forever. However, for those who are interested in understanding mankind's behavior, this book will appeal."

CLINICAL PERIMETRY. By H. M. Traquair, M.D., F.R.C.S.Ed., assistant ophthalmic surgeon, Royal Infirmary, Edinburgh; ophthalmic surgeon, Chalmers Hospital, Edinburgh, etc. 264 pages, with 164 illustrations and a colored plate. Cloth. Price $13.50. The C. V. Mosby Company, St. Louis, 1927.

Ordinarily the subject of perimetry is discussed in such a technical and comprehensive manner that it becomes tiresome even to the trained ophthalmologists and more so to the student. Not enough attention is given to the practical side of perimetry or its value in the diagnosis and progress of diseased eye conditions. Fortunately in this book of Traquair's no attempt is made to deal exhaustively with perimetry, but only to introduce the reader to its essential principles considered in their clinical aspects. The author very frankly says that the presentation of the subject has been limited to what the clinician is likely to find useful. No attempt is made to review the numerous variations of methods, or descriptions of elaborate and costly apparatus, and for the reason that such discussions or descriptions are considered superfluous. The author confines himself to the study and application of simple principles, and the use of what is known as the quantitative method of perimetry, the value of which, both as a means of diagnosis and research, are demonstrated. Emphasis has been placed upon the anatomy of the visual power, the importance of which to the perimetrist can hardly be over-estimated, and some reference has been made to pathological conditions with a view to correlating these factors with alterations in function, and finding rational significance of field changes. The significance of alterations in the fields, and especially in relation to diagnosis, and the necessity of considering such changes as part only of the evidence upon which the conclusions should be based, have been emphasized. The work has been founded upon a large clinical experience together with the analysis of the experience of others, and a careful analysis of means and methods which give the ophthalmologist the most trustworthy results. The book has been written in a style that is interesting and without undue elaboration. The illustrations are a feature of the text, and the publisher's work is excellently done. No ophthalmologist can afford to ignore perimetry, and we have no hesitation in recommending this work as one of the most valuable of its kind for the practice of ophthalmology as well as the student who is preparing for special work.

TRUTH ABOUT MEDICINES

NEW AND NONOFFICIAL REMEDIES

DIPHTHERIA TOXIN-ANTITOXIN MIXTURE.—The antitoxin used in the toxin-antitoxin mixture (New and Nonofficial Remedies, 1928, p. 366) is produced from the horse, goat or sheep.

DIPHTHERIA TOXIN-ANTITOXIN MIXTURE (NEW FORMULA) (SHEEP)-SQUIBB.—Each cubic centimeter represents 0.1 L+ dose of diphtheria toxin neutralized with the required amount of antitoxin obtained from the sheep. Marketed in packages of three ampules, each ampule containing 1 cc. of the mixture; in vials containing, respectively, 10, 20 and 30 cc.; and in packages of thirty 1 cc. ampules. E. R. Squibb & Sons, New York.

PARATHYROID HORMONE-SQUIBB.—A stable aqueous solution containing the active principle or principles of the bovine parathyroid glands and having the property

of relieving the symptoms of parathyroid tetany and of increasing the calcium content of the blood serum. It is standardized physiologically. Parathyroid Hormone-Squibb is claimed to be specific for normal or parathyroidectomized man when injected subcutaneously for increasing the level of the blood serum calcium. It is marketed in 5 cc. vials. E. R. Squibb & Sons, New York.

TETANUS ANTITOXIN.—This tetanus antitoxin, concentrated (New and Nonofficial Remedies, 1928, p. 356) is also marketed in a syringe containing 20,000 units Eli Lilly & Co., Indianapolis. (*Journal A. M. A.*, October 13, 1928, p. 1109).

DIPHTHERIA TOXIN FOR THE SCHICK TEST.—This diphtheria immunity test (New and Nonofficial Remedies, 1928, p. 291) is also marketed in packages of two 10 cc. vials, sufficient for 100 test doses. Schick Test Control is also supplied in packages of one 10 cc. vial, sufficient for at least 100 tests. H. K. Mulford Co., Philadelphia.

TETANUS ANTITOXIN GLOBULIN.—This tetanus antitoxin, concentrated (New and Nonofficial Remedies, 1928, p. 356), is also marketed in piston syringe containers, containing 20,000 units. Parke, Davis & Co., Detroit.

DIPHTHERIA TOXIN-ANTITOXIN MIXTURE 0.1 L+ (NON-SENSITIZING).—Each cc. constitutes a single dose of diphtheria toxin neutralized with the proper amount of antitoxin produced from goats (New and Nonofficial Remedies, 1928, p. 366 and THE JOURNAL, October 13, 1928, p. 1109). It is marketed in packages of three vials, each containing 1 cc.; in packages of one vial containing 10 cc.; and in packages of one vial containing 30 cc. United States Standard Products Co., Woodward, Wis. (*Journal A. M. A.*, October 20, 1928, p. 1193.)

PROPAGANDA FOR REFORM

PHENYLAMINOETHANOL SULPHATE.—The Council on Pharmacy and Chemistry publishes a preliminary report on phenylaminoethanol sulphate which has recently been synthesized, and studied pharmacologically and clinically and proposed for use as a substitute for ephedrine. The A. M. A. Chemical Laboratory examined a specimen of the product used for the recent clinical work and found it to be a pure substance having the composition claimed. Although the Council will await confirmatory reports before accepting the substance for New and Nonofficial Remedies, it believes that the results already recorded justify further experimentation clinically. To avoid confusion, the Council has adopted the name "phenylaminoethanol sulphate". (*Jour. A. M. A.*, October 6, 1928, p. 1037).

IRRADIATION AND THE BLOOD.—The enthusiasms that have been aroused by the demonstrable physiologic potency of irradiation with ultraviolet rays generated in various ways call for restraint before they are permitted to promote therapeutic procedures that may presently be discovered to be ill-advised. Not long ago it was shown that the exposure of dogs to carbon arc radiation may give rise to variable results with respect to the changes in the content of erythrocytes in the blood. Depending on the dosage, increases and decreases were noted. A continuation of this work shows that changes in the plasma volume also may take place. The investigators believe that erythrocytes may actually be destroyed by excessive irradiation with massive exposures. Our uncertain knowledge in regard to the effects of irradiation should serve as a warning against undue ventures that may actually border on quackery, until further explicit knowledge is available. (*Journal A. M. A.*, October 6, 1928, p. 1038).

LIVER TREATMENT IN SPRUE.—From reports it appears that anemia of sprue in which there is a high color index and fewer than 2,000,000 erythrocytes can be expected to respond to the administration of Minot's liver fraction (Liver Extract No. 343, N.N.R.) with a shower of reticulocytes, unless the bone marrow is hypoplastic. Clinical cure, apparently, follows, but the type of pernicious anemia persists for at least two months after liver extract has been administered. A recent report of a case of sprue treated with Liver Extract No. 343, N.N.R. refers to a patient who was admitted to the hospital in a moribund condition and who has apparently recovered completely. (*Jour. A. M. A.*, October 6, 1928, p. 1038).

THE PRECURSER OF VITAMIN D: ERGOSTEROL.—Following the discovery that foods may be made antirachitic by irradiation with ultraviolet light, it was shown that the substance which is activated by the rays is ergosterol. A precurser to vitamin D had thus become established. Activated ergosterol was shown to be a hundred thousand times as effective from the standpoint of its effects on rachitic animals, as cod liver oil. This irradiated ergosterol needs careful standardization and evaluation in terms of curative potency, because an excessive dose may cause "hypermineralization" in the blood in the normal as well as the rachitic infant. The usual dose in infants for cure thus far has been given in the form of oil solutions containing the equivalent of from 2.5 to 5 mgr. of irradiated ergosterol. Evidence has been presented which strengthens the assumption that only a molecular structure such as that possessed by ergosterol enables a sterol to be photochemically converted into vitamin D, and confirms the view that ergosterol is the specific parent substance of vitamin D. Fortunately, there need be no limitations to its availability for therapeutic use if this is finally established on a sound basis. (*Jour. A. M. A.*, October 13, 1928, p. 1110).

CLEANING THE "DENTAL AUGEAN STABLES".—For years the dental profession, as the medical profession before it, has had its share of "peddlers" of worthless nostrums and quack remedies. Therefore the recent action of the American Dental Association pointing toward the establishments of a bureau of chemistry for the examination of dental drugs is noted with satisfaction. The American Dental Association will render a public service by exposing many of the worthless "dentrifices", "mouthwashes", "pyorrhea remedies" and whatnot purveyed to the public. Equally important and a more fertile field for activity are the so-called ethical remedies. The American Dental Association proposes the establishment of its own council on pharmacy and chemistry. Congratulations to dentistry in its campaign to clear the "Augean stables" of dental materia medica. (*Jour. A. M. A.*, October 13, 1928, p. 1113).

ALFRED ERNEST GEORGE HALL.—Another notorious example of the quack psychologists of the quasi-medical type and who bids fair to rival the redoubtable Orlando Edgar Miller is that of Alfred Ernest George Hall. Although he claims to hold degrees from several institutions, including the University of London, he is not an M. D.; he has never been graduated by any reputable medical school, nor has he ever been licensed to practice medicine in the United States or Canada. He poses as holding important offices in various organizations, some of which, it is opined, have no existence. He has a long record of quackish activity, claiming to be a specialist of London, Paris, Geneva and Vienna and giving discourses on sex subjects. His latest venture was the establishment of an "annual summer school" of the American Academy of Psychological Research at Richmond, Indiana, where he delivered unscientific lectures on sexual subjects. This organization is one that has been brought into existence by a motley group of faddists, fakers or quacks, and shows the close relationship between the quack psychology scheme, and various physicians and chiropractors, Abrams and Koch disciples and other individuals. (*Jour. A. M. A.*, October 13, 1928, p. 1125).

OSMOGEN.—According to the advertising, Osmogen is "a combination of proteolytic substances", "a proto-enzyme treatment for diabetes" "perfected" by one Horovitz. It is a product of the "Lipoidol Laboratories, Inc.", of which A. S. Horovitz is president. No product of this company has been reported on by the Council on Pharmacy and Chemistry, though *The Journal of the A.*

M. A. contained a note on Gonolin and Luesan, manufactured by this company and formerly advertised by the Horovitz Biochemic Laboratories Co., of which A. S. Horovitz was president. In a recent advertising booklet, Osmogen and Gonolin are listed with other so-called proto-enzyme preparations recommended for use in a list of serious conditions ranging from alcoholism to tuberculosis. The therapeutic claims and the indefinitely stated composition for these products bear close resemblance to those made for a series of preparations called Proteogens of the Wm. S. Merrell Company, which were said to have been originated by A. S. Horovitz and which were reported on unfavorably by the Council. Subsequently Horovitz left the Merrill Company and started in business for himself. A. S. Horovitz was the originator of a discredited cancer cure. Autolysin, which gained some publicity more than ten years ago. (*Jour. A. M. A.*, October 13, 1928, p. 1129).

BENZYL ALCOHOL AS A LOCAL ANESTHETIC.—Benzyl alcohol is probably not needed as a local anesthetic, in view of the superior anesthetic qualities of other bodies. It is relatively more irritating and its action of shorter duration than that of non-volatile agents (*Jour. A. M. A.*, October 13, 1928, p. 1131).

OVARIALHORMON FOLLICULIN MENFORMON.—The Council on Pharmacy and Chemistry reports that an ovarian preparation made on the basis of the work of Laqueur is marketed as Ovarialhormon Folliculin Menformon by two European firms and the product of one of these is marketed in the United States by the Marvell Pharmacal Company, New York. According to the information received, the commercial product may be obtained (a) from the placenta of women and animals, (b) from the liquor folliculi of cattle and (c) from the urine of pregnant women. Laqueur states that Menformon may be obtained from the urine and testes of men. The methods which were given the Council were so general in character that they could not be taken as establishing the character or identity of Ovarialhormon-Folliculin Menformon. The Council reports that it was unable to obtain evidence of the efficiency of the preparation in the strength in which it is marketed. The Council has postponed consideration of the acceptance of this product for New and Nonofficial Remedies to await confirmative evidence for its therapeutic value and more definite information with regard to the identity of the product. (*Jour. A. M. A.*, October 20, 1928, p. 1193).

THYANGOL PASTILLES NOT ACCEPTABLE FOR N. N. R.—The Council on Pharmacy and Chemistry reports that Thyangol-Pastilles, distributed in the United States by the Sterling Products Corporation, New York, are claimed to contain in each pastille: "Anaesthesin, 0.03, Phenacetin, 0.08, Thymol, Menthol, Olem Eucolypti aa. 0.0015, Sacch. alb. ad 1.0 gr." In this statement "gr." stands for gram; therefore, each pastille contains 0.03 Gm. Anesthesin (ethyl aminobenzoate, U. S. P.) and 0.08 Gm. Phenacetin (acetphenetidin, U. S. P.) in a base of sugar with aromatic oils. The use of the pastille is proposed by the manufacturer in coughs and angina, dysphagia and pains in swallowing due to various causes, and in dental practice to reduce sensitiveness when taking casts. The Council found Thyangol-Pastilles unacceptable for New and Nonofficial Remedies because the routine administration of a mixture of ethyl amino-benzoate and acetphenetidin is irrational; because the claims are exaggerated; and because the name is not descriptive of the potent ingredients. (*Jour. A. M. A.*, October 20, 1928, p. 1193).

OVARIAN HORMONES AND OVARIAN ORGANOTHERAPY.—The evidence from the experimental laboratories and the clinics, accumulated especially during the last few decades, points to the conclusion that the mammalian ovaries exercise their influence on the so-called secondary sex characters and the sex life of the mammalian female through the mechanism of the hormone or hormones produced by some element in the ovary. It is therefore rational to treat or attempt to treat symptoms due or presumably due to ovarian insufficiency by substitution therapy. Summing up the extensive clinical trials with ovarian preparations, generally administered orally, Novak, in 1924, stated that the results are rarely striking and often nil to the level-headed observer. Much work has been done on the separation and concentration of the so-called follicular ovarian hormone and preparations have been obtained which, when administered parenterally, are reliably reported to stimulate uterine growth and to introduce changes similar to estrus in spayed animals. To date the use of such preparations on patients has been neither extensive nor encouraging. The various ovarian hormone preparations that now seem sufficiently purified to be introduced hypodermically without serious results to the patients should be given trial in definitely uncomplicated ovarian deficiency in order that more may be learned as to their actual effects. (*Jour. A. M. A.*, October 20, 1928, p. 1194).

MU-SOL-DENT.—This is marketed by the V. B. Corporation of Pittsburgh, Pa., as "the only existing non-irritating solvent of mucin and mucous." It is said to be "efficient in the prevention and treatment of sore throat and colds" and a product that will greatly hasten the healing of wounds and burns. Especially it is recommended for the removal of mucin plaques and film on teeth. The national organization of dentists has recently turned its attention to the problem of giving its members and the public the facts regarding widely advertised medicinal preparations in the dental field and the first preparation analyzed by its chemist (working in the A. M. A. Chemical Laboratory) is Mu-Sol-Dent. It was found to be essentially a solution of common salt, potassium chloride and trisodium phosphate in water. There is present also essential oils and coloring matter. And this is the preparation that is said to prevent tooth decay, tartar and pyorrhea, and to be good for catarrh, hay-fever and sore throat. (*Jour. A. M. A.*, October 20, 1928, p. 1211).

UNGUENTUM MAZON.—An inquiry was sent to the Belmont Laboratories, Inc., to ascertain whether the composition of Mazon and Mazon Soap and Ointment was secret, and if not, what were the formulas. The Belmont Laboratories, Inc., replied as follows: "We very much regret our inability to comply with the request contained in your letter dated September 21 with reference to Mazon and Mazon Soap for the reason that the composition of both of these products is secret." It seems hard to believe that there still are pharmaceutic houses that will endeavor to exploit products of secret composition to the medical profession. The physicians who are asked to buy such products should refer the detail men to the paragraph in the Code of Ethics of the American Medical Association which states that . . . it is equally unethical to prescribe or dispense secret medicines or other secret remedial agents, or manufacture or promote their use in any way. (*Jour. A. M. A.*, October 20, 1928, p. 1213.)

POWER CANDY MINERALIZED.—The Council on Pharmacy and Chemistry reports that Granger Farms, Buskirk, N. Y., requested acceptance for New and Nonofficial Remedies of Granger Farms Power Candy Mineralized. The candy is claimed to contain one part of tincture of iodine U. S. P. in 5,000; one part in 4,000 of ferrous lactate; 1 per cent of calcium carbonate; 1 per cent of calcium phosphate tribasic; and one-twentieth of 1 per cent of calcium glycerophosphate. The proprietor stated that he is "convinced that with the exception of epidemics and injuries, about 99.44 per cent of the ills that American people are suffering from are due directly or indirectly to the lack of proper mineralization of their foods and especially the lack of calcium." The Council held Power Candy Mineralized not to come within the scope of New and Nonofficial Remedies. Because of the unwarranted claims made for it, the use of the product, in the opinion of the Council, is contrary to

the public welfare. The candy appeared to be a commercial venture using public health or welfare as sales talk, and in so doing the promoters go beyond the proved facts in (1) claiming that calcium deficiency is almost universal in this country (2) claiming that such diseases as diabetes and cancer are due to calcium deficient diet; and (3) claiming that mineralized candies are an efficient and safe method of correcting the alleged calcium deficient diet. (*Jour. A. M. A.*, October 27, 1928, p. 1289).

ABSTRACTS

HOW TO DEAL WITH CHIROPRACTIC

A California correspondent of *Clinical Medicine and Surgery* has written an article on "How to Deal with Chiropractic" which we are reprinting from *Clinical Medicine and Surgery,* with a comment from the editor of that journal to the effect that it is one of the soundest and most plausible articles along this line that he has seen. He further says: "Bitter and general condemnation of irregular methods of healing do the physician no good in the estimation of the patron, or in his own eyes. It is worse than foolishness to talk about matters on which we are uninformed. Let us find out just what the irregular claims to do and what is the basis of his claim. If there is any sound or scientific reason in his procedures let us use them for the benefit of our patients. No one has a better right to do so than has the medical graduate. If not, let us show our patients just where the fallacies lie."

The article to which we have referred is as follows:

"There is a great deal of truth in the saying that 'every knock is a boost.'

"Now that the woods are full of manipulators, adjustors and bone movers, who flagrantly broadcast their advertising in all directions, it should not surprise nor vex us when we are seriously questioned by our patients concerning the methods of these cults. All-too-often we are inclined to scoff, sneer or waive the question, which attitude gives our patients the wrong impression. Ridicule without reasonable explanation of the fallacies underlying such treatment gives the impression that we know not whereof we speak. Denunciation instead of intelligent refutation implies jealousy. It does rather vex us when we find that some of our best patients have surreptitiously visited members of these cults and have obtained more or less temporary relief. How then are we to answer their questions in order to maintain their confidence and patronage? Patient explanation and careful teaching by illustration seem to be the most effective method. Let a few cases explain.

"Take, for example, Mr. Smith. He has been told that *one* of his vertebrae was subluxated—yes, 'distinctly out of line' and, *snap,* 'Dr.' X put it in the proper place again. Does Mr. Smith know anything about the anatomy of the spinal column? Nothing! Then let us take Mr. Smith to the nearest meat market, select a mutton carcass that has been sawed in half, and give him a little lesson in anatomy. Show him how exceedingly difficult it is to move vertebrae, even when the spinal column is sawed in half. Show how nature has encased and protected the delicate spinal cord. Show the relative difference in size between the vertebrae foramen and the spinal nerve; how it is cushioned in fat and how pressure on it, even by the greatest effort of bending the spinal column, is practically impossible. Then explain the technic of the snap by pushing over the ligaments and letting them slip suddenly back into place. Mr. Smith is smiling as he departs. He will be back again."

"But here is Mr. Jones. 'Dr.' X. has explained to him in great detail that nerve 'impingement,' or pressure on a nerve, is just like someone standing on a hose, thereby stopping the stream of water. All one has to do is to remove the pressure and, presto! the stream flows on.

"But wait just a moment! Water flowing through a hose can be compared to blood flowing through an artery, but does nervous energy flow through tht nerve in the same manner? Hardly! The nerve energy is more rationally compared to electricity running through a wire, and Mr. Jones knows that standing on an electric wire does not affect the flow of electricity through that wire. But still, Mr. Jones is just a little skeptical. So you have him sit down while you press gently on one of his nerves, the left ulner, which is so superficial at the elbow. After five minutes pressure a certain part of the left hand is numb—'asleep'—and, if pressure is continued long enough, paralysis and anesthesia result. Then you remove the pressure and note the sensation, especially a tingling. as the part that has been 'asleep' reawakens. Did Mr. Jones ever feel such tingling when 'Dr.' X. removed the pressure from that 'impinged' spinal nerve? Smilingly, Mr. Jones departs.

"Then there is Mrs. Brown. Her 'doctor' is the real Spanish kind; that fiery type so aptly illustrated in the popular comedy entitled 'Cradle Snatchers.' As he works his fingers up and down her spine she loses all sensation of her pains, and 'just feels a heavenly warmth all over her.' Does Mrs. Brown know that there is a chain of sympathetic ganglia up and down her spine, on either side; that these ganglia are rich in adrenalin; and that massaging or punching over them stimulates them, thereby liberating more adrenalin into the circulation, which causes the warmth and relaxation? Now Mrs. Brown can see why it is necessary to continue these 'treatments' indefinitely and why the good effects last so short a time. She is then more interested in how to build up her depleted adrenal reserves in a better, more permanent way, and is thankful to her regular physician for taking the trouble to explain these things to her.

"One great weakness in the arguments of the cultist is exhibited in the infallibility of the adjuster. Strange as it may seem, he always knows just how far or how much to adjust. We of the regular profession do not boast of such perfection. For instance, if one hundred different surgeons set one hundred different fractured femurs, the results will not be one hundred per cent perfect. Yet the adjuster never makes the terrible mistake of slipping a vertebrae a little too far, thus causing an impingment on the opposite nerve. It does seem that, if vertebrae got out of line so easily, it might be a dangerous practice to go pushing them about. But we never hear of any paralysis or opposite impingements—nothing but one hundred percent results. Then we study the terrible deformities of the spine of the hunch-backed patient, who shows no symptoms of lateral nerve impingement whatsoever, and we wonder anew how a theory so utterly ridiculous could live so long. Even as we wonder, the adjusters are surreptitiously adding diet, exercise, electricity and massage to their armamentarium, thereby admitting the inefficacy of their original beliefs. And so cultism goes on and on.

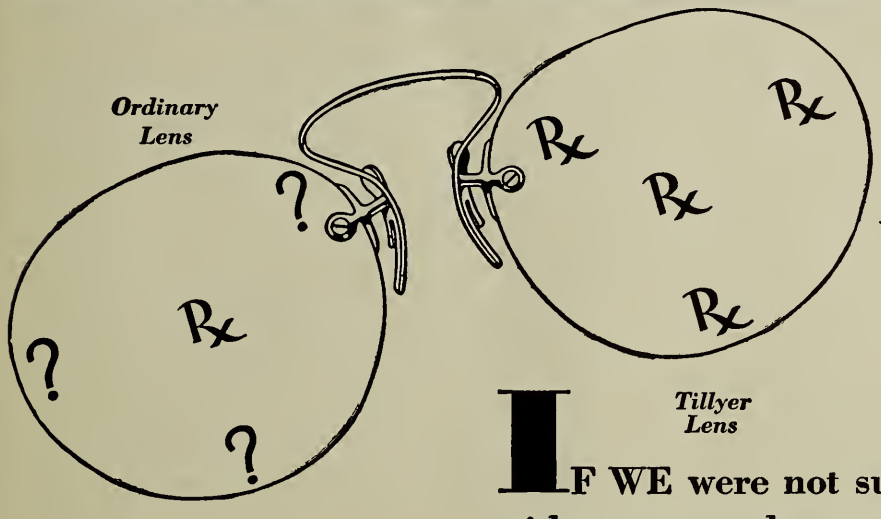
"Let us be kind, but clever, in explaining apparent miracles, and wiser in understanding the psychology of our patients than are our blatantly advertised brethren, at the same time losing no opportunity to maintain the efficiency of our own methods of relieving human suffering. The best doctors are good teachers whose explanations are adequate and whose criticisms are constructive."

ACUTE, PAINFUL, ANKYLOSING ARTHRITIS

Walter G. Stern, Cleveland (*Journal A. M. A.*, Oct. 27, 1928), reports the case of a physician who was suddenly seized with a most intense, deep-seated, gnawing pain in the hip joint, which was not relieved by the usual treatment of hot compresses and which grew steadily worse and was exacerbated by the slightest motion of the patient's body. Larger and larger doses of opiates had to be given, until at last the patient was almost constantly under the influence of hypodermics. He was rap-

(Continued on Adv. Page xx)

TO OCULISTS:



IF WE were not sure that you, yourself, with your own glasses, would notice increased clarity with Tillyer lenses, we'd hardly venture to ask that you try them. *Will you, yourself, wear a pair?* Our research laboratories vouch for the new computations that make them more accurate and our 150 prescription shops are equipped with new Tillyer machinery so that you can have Tillyer lenses on Rx, anywhere in the United States. First of all, they interpret your prescription as accurately in the margins as the center, and second, they are polished in the same way that fine camera and telescopic lenses are polished.

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ABSTRACTS

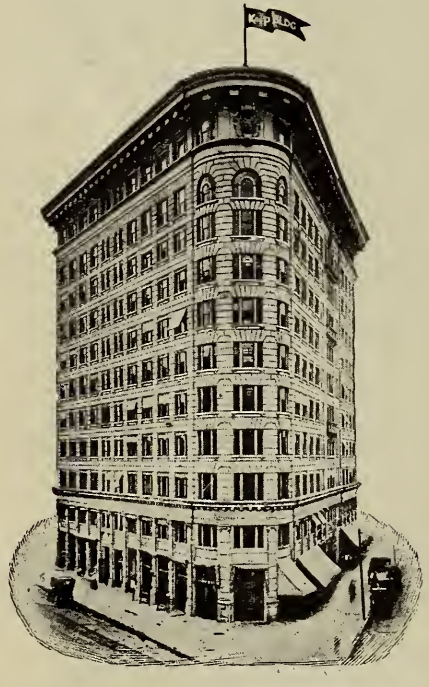
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idly losing in weight and strength as a result of the loss of sleep and inability to take nourishment. There was not an unusual rise in the temperature curve. The hip joint was not swollen, and careful palpation did not show any specially localized tenderness over any one spot—there was only a generalized tenderness; but the slightest motion of any kind was enough to set up most violent paroxysms of pain. Free fluid in the hip joint was absent, and the roentgenograms were negative. Repeated aspirations did not reveal any excessive joint fluid, and the few drops of blood-stained synovial fluid aspirated were negative both to aerobic and anaerobic cultures. None of the usual signs of arthritis being present and ordinary Buck's extension not relieving the sufferings in the least, the patient was held to be an acute morphine addict. A suggestion was made that this case might belong to the type of dry arthritis. A well fitting plaster cast was applied from toes to arm-pits, under anesthesia, and when the patient was returned to his room he enjoyed the first natural sleep that he had had in weeks. From this time on the pain subsided, although a few flare-ups lasting from four to eight hours each were inevitable. With the subsiding of pain the patient soon regained his appetite, and within ten weeks had gained so much in weight that it became necessary to take off the cast. At this time a roentgenogram showed an almost complete absorption of the cartilages of the hip joint; the ordinary shadow of the joint was obliterated, and the shadow of bone touched bone. There was absolutely no evidence of bone destruction or of periosteal proliferation anywhere. Clinically, the hip was firmly ankylosed. Light fixation was employed for another four weeks, after which the patient was so much improved that he got up on crutches and not very long afterward was able to walk with a cane and assume his medical practice with an almost completely ankylosed but painless hip.

HEMORRHAGIC DISEASE

The two patients whose records are presented by W. D. Little and Wendell W. Ayres, Indianapolis (*Journal A. M. A.*, Oct. 27, 1928), are sisters belonging in the fifth generation on the accompanying chart. Of ten half-brothers and half-sisters none show the tendency to bleed, but six out of nine children of the patient's mother had a bleeding tendency and five of them are dead as the result of it. The mother is a "bleeder", as are three of her brothers and her one sister. One brother is unaffected. Five of the nephews and nieces have an undoubted bleeding tendency. The patient's maternal grandmother and two of her brothers all had severe hemorrhages from slight scratches and purpuric spots from slight bruises. These two men became blind from retinal hemorrhages. The maternal great grandmother bruised and bled easily. The maternal grandmother and maternal great grandmother were jaundiced much of the time when young. The maternal grandfather was a definite mild type bleeder, as was evidenced by his bruising easily and by prolonged bleeding from slight scratches and cuts. He had no trouble after he became of age. Several of the persons seemed to have the hemolytic jaundice type of bleeding. Severe nosebleed up to maturity was the only symptom in some of them. The outstanding clinical finding in the first patient's record is a persistently prolonged bleeding time which was apparently not affected by any therapeutic measure used by us. Her sister had a similar persistent and constant prolongation of bleeding time without any other abnormal condition except enlargement of the spleen. Although hemorrhages from the gums, nose and uterus were controlled, the bleeding time before and after the hemorrhages did not change.

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SOCIETIES AND INSTITUTIONS

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marked auricular fibrillation. She had a stroke two years ago and now has irregular shaking of the left arm and hand and some difficulty in walking.

The clinic was quite well attended and much interest shown.

Evening address: "Heart Failure" (Angina Pectoris) Dr. Robert Moore:

Heart failure is a relative term and refers to a circulation inadequate to meet the demands of the individual. Failure may be of the congestive or of the anginal type. In the former cyanosis dyspnea and edema are the outstanding symptoms. Failure of the anginal type is indicated by pain, and is usually found in a stout, well nourished, plethoric man. The pain may vary from a mild cramp or pressure sensation to excruciating pain. The pain is usually constrictive in nature and comes on after exertion. After the best physical examination, including x-ray and electro cardiograph no structural or functional change may be demonstrated. Never tell a patient he has angina, but tell him he has a fatigued heart. To make a diagnosis of angnia, give the patient 1/100 gr. of nitroglycerine, if during an attack this tablet dissolved on the tongue gives relief, and especially if the blood pressure rises 20 to 40 points during an attack, the diagnosis may be made.

The patient is usually seized while walking, or after eating. When standing still the uneasiness vanishes; at other times the patient is perfectly well. If the condition has existed for over a year, the pain will not vanish so readily, and may even come on while lying down. The pain may be precordial, but sometimes is in the upper part of the chest; it may be right or left and often extends down the arm; arm may feel numb and swollen. (The above taken from Heverdin's Commentaries 1782).

Treatment: Formerly the expectancy of life was one and one-half years; today a patient with angina pectoris may live six to ten years. The patient must rearrange his affairs, habits, eating, and exercise; he must train himself not to react to little things. He should not climb stairs. He should not work Friday, Saturday and Sunday. He should eat his breakfast in bed, rest after lunch, come home early and rest before the evening meal, he should keep his mind off his condition, go to movies, etc.

Many have high blood pressure. For this use ammonium bromide 10-15 gr. tid. or erythrol tetranitrate gives satisfactory results. Once in ten days 10 gr. of diuretin twice a day. Ninety per cent of cases occur in men after fifty.

Coronary Occlusion:

a. Status anginosa, long continued, severe pain.
b. Status dyspneus, shortness of breath beyond dyspnea, which makes the patient very restless.
c. Status gastralgeus in which pain is referred to the epigastric region.

There is severe pain under the lower one-third of the sternum, breathlessness, perspiration, ashy pallor with cyanosis, cold clammy skin, air hunger, restlessness. Pulse at wrist may be gone; the blood pressure may be 40 or even 0, even though before it was high. Then comes shock, collapse and suppression of urine.

When the vessel first closes the pain and shock are first noticed, this is followed by myocardial weakness with the low blood pressure.

The infarct in the heart may produce a localized pericorditis with a friction rub (this is present only if the infarct is anterior and does not last long).

The gastralgia is severe and persistent, even under large doses of morphine. The white blood count rises to 20,000 or more in an hour. There is fever. Edema is late because anginal failure may lead into congestive failure.

The prognosis depends on the size of the vessel occluded. Three out of five die (Barker). If the patient survives, his activity will be decreased fifty per cent. Most of them have a low myocardial par and cannot exert much.

Treatment: 1. Prevention—slow up and avoid hurry, sudden effort, minimize worry, do not overload stomach.
2. Large doses of morphine.
3. No cathartics.
4. No food for twenty-four to forty-eight hours.
5. Should not be moved or turned over in bed.
6. Small enema or proctoclysis given slowly through small catheter.
7. Avoid vaso-dilators.
8. Digitalis for the myocardial failure. (Avoid in the first shock.)
9. Euphyllin in small doses.

Death may occur instantly usually when large vessel is involved.The patient may withstand the immediate shock, but die in one or two weeks of myocardial failure; or he may improve and die later of a rupture through a softening of the infarct.

A patient with an occluded coronary vessel should remain in bed at least two months.

J. C. BURKLE, Secretary.

CARROLL COUNTY MEDICAL SOCIETY

The Carroll County Medical Society met every month with the exception of January, February and March.

The following program was rendered the physicians and their subjects being as follows: :

April—A. G. Funkhouser, M.D., of Indianapolis—"Treatment of Constipation."

May—Alfred Henry, M.D., of Indianapolis—"Methods Used in Diagnosis of Pulmonary Tuberculosis."

June—LeRoy Smith, M.D., of Indianapolis—"Hematura in the Urine."

July—Chas. R. Sowders, M.D., of Indianapolis —"Blood Pressure and the Importance of Yearly Examinations." Dr. Kuns led the discussion.

August—Dr. Henshaw, dean of the Indiana Dental College of Indianapolis—"The Advancement of Dentistry and Medicine."

September—Frank Cregor, M.D., of Indianapolis—"Cutaneous Skin Cancer."

October—A. Mendenhall, M.D., of Indianapolis —"Some of the Newer Things in Obstetrics."

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